Exhibit 9

to

Declaration of Declaration of Andrew S. Hansen

Ralph Simon v. Select Comfort Retail Corp.,
and Select Comfort Corporation
Case No.: 4:14-cv-1136 (JAR)

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

RALPH SIMON,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No.
	)	4:14-cv-1136
SELECT COMFORT RETAIL, CORP.,	)	(JAR)
	)	
and	)	
	)	
SELECT COMFORT CORPORATION,	)	
	)	
	)	
Defendants.	)	

The discovery deposition of DR. ERNEST CHIODO, called by the Defendants, for examination, pursuant to notice, taken before LAURA MUKAHIRN, CSR, a notary public within and for the County of Cook and State of Illinois, at 227 West Monroe Street, Chicago, Illinois, on August 20, 2015, scheduled to commence at 10:40 o'clock a.m.

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Defendants;

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EXHIBITS

(Witness sworn.)

DR. ERNEST CHIODO,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

Examination

By Ms. Fisher

Q. Good morning, Dr. Chiodo. Did I say that right?

A. Yes, ma'am. That's fine.

Q. Chiodo?

A. I say Chiodo, but don't worry. Everybody in my family pronounces it differently.

Q. I'm going to try to recall that as we move on. We met previously. My name is Heidi Fisher. I'm an attorney with Oppenheimer, Wolff & Donnelly out of Minneapolis, and I represent Select Comfort Corporation and Select Comfort Retail Corporation in this litigation.

You understand you're at a deposition today to answer questions in the case of Ralph Simon vs. Select Comfort. When I say Select Comfort, I'm going to

refer to both Select Comfort Retail Corporation and Select Comfort Corporation.

Can you state your entire name for the record, please?

A. Ernest Paul Chiodo, C-H-I-O-D-O.

Q. And, Mr. Chiodo -- or Dr. Chiodo, I understand you've been deposed multiple times before?

A. Yes, ma'am.

Q. So I'm going to dispense with most of the preliminary instructions with respect to depositions. If at any time you misunderstand my question, just please ask me to rephrase, or need to take a break. And I think with that, we'll just get started.

Where do you currently live?

A. My domicile is Michigan, suburban Detroit. But I do have homes and offices in Chicago and West Palm Beach, Florida, in addition to suburban Detroit.

Q. You said homes and businesses. Let's talk about your businesses first. What business do you -- Do you have a

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business in Michigan?
A. Well, I don't call it a business. I call it a practice. But I have a professional office in Clinton Township Michigan.
Q. Okay. When you say professional office, is that a medical office or a legal office?
A. Both.
Q. Okay. Same office for both practices?
A. Yes. Yes, ma'am. I'm obviously not the attorney for people that I'm their physician, and not the physician for the people that I'm their attorney.
Q. Understood. You have a business in Florida. Can you tell me about that a little bit?
A. I have a professional practice there. I'm not practice -- I'm not licensed to practice law in Florida, so my practice is my practice other than the practice of law. When I say "my practice," my practice includes being a physician and a physician utilizing my various other

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expertise: Biomedical engineering, industrial hygiene, toxicology, epidemiology. So I maintain a medical office in West Palm Beach, Florida.
Q. What is the focus of that practice in West Palm Beach, Florida?
A. The focus of that practice is where I have a clinical relationship, that would be a physician/patient relationship, with individuals is occupational and environmental medicine and toxicology.
Q. What percentage of the patients in your West Palm Beach, Florida business are litigants or potential litigants in a court case?
A. I think it would be 100 percent, because I just opened up that office. And the people that I've dealt are -- have some litigation going on, which is not unusual with occupational medicine. Because occupational medicine is one of those specialties that if you're -- you are uncomfortable with being deposed, you don't want to do that specialty. Because virtually every patient you have is going

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to have some type of litigation going on; third-party litigation or workers' comp litigation. So that's part and parcel of occupational medicine. It's not with other personalities like general internal medicine. I don't do any general internal medicine in Florida. I do have a small general internal medicine practice in Michigan. And then those patients I would say none of them have any litigation going on.
Q. Okay. With respect to your --
A. None that I know of.
Q. With respect to your Florida business, you say you just opened the office. When was that?
A. Probably had the office for about a year, but setting things up and just started seeing people -- started kind of -- started taking people into the occupational medicine practice recently. Within the last couple months.
Q. Okay. With respect to the patients that you've seen within the last couple months, are they plaintiffs or

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defendants or -- I'm sorry. Are they all plaintiffs or were you hired by the defense in any of those cases?
A. Well, if I was hired by defense, then I'm not their doctor. So what I'm referring to is where I have a physician/patient relationship with the individual. Now, I've done in Florida other work as a forensic expert, and there I would say the vast majority of my work in Florida has been as a defense expert. Because not only toxin and occupational environmental medicine cases, usually mold cases, but also -- I'm also a biomedical engineer. So I get involved in vehicular impact biomechanics cases. And in those cases I'm almost always a defense expert.
Q. When you say mold cases, is it your testimony that you're usually a defense expert in mold cases?
A. No. It's just that the cases where I've been down in Florida to date I would say -- I'm trying to think about how many cases. It's hard for me to say. I would be guessing, and I'm not supposed to

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guess. But I don't recall, as I'm sitting here, being an expert for plaintiff in a mold case as of date. I have been an expert for defense in mold cases, in at least a couple mold cases that I can think of, I can think of offhand.

Q. So your total number of mold cases would be -- would you put it under five?

A. I would say it would be in that general magnitude.

MR. CORWIN: In Florida?

THE WITNESS: In Florida.

BY MS. FISHER:

Q. In Florida. Okay. How about elsewhere?

A. Oh, quite a few. I mean it's --

Q. More than 50?

A. No. I don't know if it would be -- I would be guessing, but it's something that comes up not infrequently.

Q. In a little while we'll take a look at your CV and you can -- Would you be able to, by looking at your CV, figure out

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which ones of those were related to mold?

A. CV, no.

Q. Or your list of cases?

A. I brought a Federal Rule 26 testimony list. I may or -- I may or may not be able to. If you want go through it, I can see if I -- if it rings a bell.

Q. Yeah. Why don't we go through that right now, as long as we're talking about it.

A. I'm going to hand you, ma'am, both my current CV, and then underneath that is my current Federal Rule 26 testimony.

Q. Is this a copy for me?

A. You can keep that.

Q. And you have a copy in front of you?

A. I do not.

Q. Okay.

A. I can loop around you, if you wish, to look over your shoulder.

MS. FISHER: Let's go ahead and mark this Exhibit 1.

MR. CORWIN: And we're doing

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Chiodo 1.

(Document marked as Dr. Chiodo Exhibit No. 1 for identification.)

THE WITNESS: And, of course, the Federal Rule 26 testimony was only those cases where I provided testimony, not necessarily cases where I'd been involved or retained as an expert.

BY MS. FISHER:

Q. Have you ever been retained as an expert or asked to be an expert, and after your initial assessment you've advised that with respect to plaintiffs you don't have a case?

A. Yes. In fact, that's usually my mode, that if -- I have a flat fee typically. And if I don't believe that I can be the expert, I give them back their money, and that has happened. I can't recall specific times. But, you know, there's a flat fee, but you obviously -- I don't know whether I'm going to be able to be plaintiff or defense expert until I've done my review.

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Q. And your flat fee is $30,000?

A. $30,000 for a review of records, writing up reports, preparation for testimony. But not for testimony time, examination. Also it doesn't cover travel time; which, of course, there's really no travel time today, because it's just by my Chicago office.

Q. Okay. So with respect to Exhibit 1, there's a portion of this that is, I would say, a little more than halfway through.

A. About 26 pages or so.

Q. Which starts at a new Page 1 after -- it looks like after the CV that's entitled Testimony. This is your Rule 26 testimony that we were just talking about?

A. Yes, ma'am.

Q. I'm going to hand it back to you.

A. And if you want to look over my shoulder, that's fine, too.

Q. Yeah. It appears to me -- I'm just going to -- I was reviewing the document you previously provided to see if

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it was the same with just a couple of additions, but it looks like there's more than just a few additions to it.
A. Right.
Q. Okay. Let's do it this way. I'll come to you. If you could tell me on this list, I don't know if you can put an X by anything there that, as you review the list, that related to mold?
A. Okay. What I think what my suggestion is, we start at the back. Because my recollection will be clearer.
Q. That works fine.
A. X next to it?
Q. Yeah. I handed the witness a pencil and he's going to mark it with an X next to each one of them.
A. Mold case.
Q. That happens to relate to a mold case to the best of his recollection.
A. Yes, ma'am.
Q. Thank you. Now, pursuant to Rule 26, this is your list of testimony in the last four years, correct?
A. In the last four years.

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Q. You have previous testimony, true?
A. I do have previous testimony. But again, just to be clear, those are cases where I actually provided testimony, not cases where I have been retained and for whatever reason there was no testimony.
Q. Okay. Understood. I'm going to handle this the same way you handled it so that things are more clear in your memory.
And before I start with this, can you tell me how much of your income is derived from being an expert?
A. I don't know, because I don't keep a log breaking it down that way. I mean I pay my taxes. My total income, the IRS doesn't need me to break down whether it's from being a forensic expert versus treating physician versus practicing law, teaching law, whatever. Because they give you a percentage, I'd have to have a -- I know my denominator, I know my gross income, but I don't have a log or keep a record to break it down based upon

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different areas of activity.
However, that being said, I recognize that you're entitled to some type of approximation. I don't know how much it is. However, I think it's a lot of what I do. It's a lot of my income. So I don't differ with the assertion that 90 percent or more of my income comes from being a forensic expert. I don't know that that's the case. It could be less. But if asked at trial the following question:
Dr. Chiodo, do you differ with the assertion that 90 percent or more of your income comes from being a forensic expert? I will simply answer, no, I don't differ with that assertion.
Now, if you start trying to play games with, well, percentage this, and take 90 percent. I didn't testify that it was 90 percent. I've had people try to do that. And they say, well, you said 90. And I said I won't differ with the assertion that it's 90 percent, but I don't know that that's the case. But just so that you have it clearly stated on the

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record. Again, if you ask at trial the following question in this matter:
Dr. Chiodo, do you differ with the assertion that 90 percent or more of your income comes from being a forensic expert? I will simply answer, no, I do not differ with that assertion.
Q. Thank you. Let's first talk about the Moore Living Trust case. Home Sales vs. Bobbie Vocke, V-O-C-K-E. What can you tell me about that case?
A. That was a case of a mobile home sold to an individual -- Actually, there were two individuals that it was sold to where there was mold contamination. And it appears that there was an attempt to conceal the mold contamination with paint. So I was retained by the plaintiffs in that matter.
Q. What kind of mold was present in the mobile home?
A. Just mold. Just mold. There was no claim concerning medical monitoring or health effects due to mold micro toxins. So the allergic effects of mold, there's no

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need to speciate. So if it's mold, any mold can cause allergic effects. The need to try to determine what type of molds were present, that comes into play if you're talking about disease or risk of disease due to mold micro toxins.

Q. So this is -- This case was purely a fraud or breach of warranty or some sort or product case with no health-related issues?

A. No. I think they were health-related issues, but they were health-issues related to the allergenic effects of mold and not due to the mold micro toxins.

Q. So they were claiming health effects in this case?

A. You know, I believe the actual case had to do with fraud concerning the product. But I think my testimony got into the issue of the minor child as to whether or not there would be some -- his health effects had a causal connection, either caused by or aggravated by mold exposure. So I did provide testimony along those

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lines. Although I think the actual case, he was not included, because he was a minor. They may sue on that matter later for him, but I think the actual case was basically the fraud case. I don't handle the pleadings, but I think that's the nature of the claim.

Q. So was it your assertion that in order to determine whether there's a causal effect with respect to the mold presence, it's not necessary to find out what kind of mold was present?

A. If you're talking about the allergenic effects, that's correct.

Q. What would you characterize as allergenic effects?

A. Oh, effects due to hypersensitivity; that is, sinusitis, rhinitis, skin rash, asthma. The effects of the mold due to mold antigens and the body's reaction to mold antigens in an individual who is sensitized to that mold.

Q. Well, wouldn't you need to know what mold antigens that individual is sensitized and compare that with what the

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mold exposure was?

A. No.

Q. Why not?

A. Because there are over 100,000 different molds, and you're not going to test somebody for 100,000 different molds. There are mold antibody panels, but usually they have 10, maybe 20 molds on them. So, no, that's not -- That's not the approach. An occupational medicine doctor would not take that approach. They would say, okay, is there mold? And is somebody having disease manifestation consistent with hypersensitivity? And what's the exposure, what are the temporal manifestations? That's how it's done. It's not done by a simple test. If that were the case, there would be no need for occupational or environmental medicine doctors. The allergist could do it, but they can't do it because they don't have the background concerning industrial hygiene sorting out causation from an occupational environmental medicine perspective. That's a very specialized area of practice that

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most physicians do not have, and that is not taught in medical school. To get that type of additional expertise, you have to have an additional degree in addition to a medical degree, and that's a Master of Public Health or something analogous to a Master of Public Health.

Q. So you mention that you need to know the exposure. How do you know the exposure?

A. Well, first off, there's -- Is there visible mold? If there's visible mold, there's mold contamination. And so there's visible mold, there's mold contamination. And looking at the circumstances, does that lead to an individual being exposed? Well, if there's visible mold on the first -- on one room on the first floor of a 30-floor high-rise, then there may not be mold exposure to somebody on Floor 30. But if there's visible mold in the area of an individual, the work area, their living area, and it is more than just a little bit of mold along the crevices in your shower, there's a mold

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contam -- visible mold contamination. Then that is manifestation of mold contamination and then that leads the occupational medicine doctor to be able to sort out whether or not disease manifestation was caused by or not caused by that exposure.

Q. Do you need to know if there's mold exposure in the air so that the person can inhale it?

A. No. In fact -- No. That's not the case. In fact, I'm going to cite to you, just so that -- and I'll tell you what I'm citing from.

Q. Please.

A. Bioaerosols: Assessment and Control by the American Conference of Governmental Industrial Hygienists. What is the American Conference of Governmental Hygienists? That is on organization that is not part of the U.S. government. It's not a governmental entity. However, it is a very well-respected entity. Its recommendations advise and guide governments throughout the world, including the U.S. government, concerning

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occupational and environmental exposure standards. And to give an idea, when OSHA came into play in the early 1970s, the permissible exposure limits for chemicals adopted as law were the threshold limit values of the American Conference of Governmental Industrial Hygienists in 1968. So it's a well-respected organization. They have a publication called Bioaerosols: Assessment and Control. The copyright is 1999. However, within the last month or two I checked with them to see if this is still their current publication, and it is. So I believe that this is a reliable authority. If somebody is involved with mold issues, this tends to be the Bible, Bioaerosols: Assessment and Control.

I'm reading now from section -- It's not laid out in pages. It's laid out in sections, chapters and then sections. And I'm reading from the seventh chapter in Section 7.4.2, Fungi. Okay. It reads the following, "Many fungi produce allergens and some fungi produce toxins. Fungal

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growth in buildings is undesirable and may cause health problems for building occupants. Although it may be difficult to establish that exposure to fungal aerosols occurs or that exposure represents a hazard, indoor fungal growth is inappropriate and should be removed. Further steps should be taken to correct conditions that lead to fungal growth so that it does not occur."

Now I'm going to get to the specific point. "Visible contamination that is confirmed by source sampling to be fungal growth is evidence of indoor contamination. Air sampling (culture or sport trap sampling) may also indicate indoor fungal growth, but should be followed by inspection and source sampling to identify the location of the fungal contamination."

Section continues on to say, "In the presence of the inevitable background concentration, the challenge for environmental sampling is to detect indoor fungal growth or entry of fungal aerosols

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from sources near OAIs." I don't know what OAIs is referring to in this matter. I think it's the occupants. "And to document the distribution of such sources to occupant exposure. Interpretation of possible indoor fungal exposure has been addressed using, A, indoor/outdoor total concentration ratios; B, comparison of the species compositions indoors and outdoors; and, C, the presence of indicator species in the indoor environment."

So what that passage means is, if you see visible mold contamination, it is mold contamination. You don't need, nor would it be appropriate, to do air testing. Air testing is for when you go into a building and somebody -- people think that they are having problems related to mold and you want to know whether there's mold contamination. So you do air testing indoors and outdoors, you speciate them so that you can do a comparison to see the species. Are the species indoors similar to those outdoors, or is there a difference indicating mold contamination. So if you

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have visible mold, you don't do air testing. It's just not indicated.
Q. It's not indicated by your profession?
A. By the profession. And, as I've just indicated, visible mold contamination is confirmed by source sampling to be fungal growth is evidence of indoor contamination. Now, I realize this case we're talking about a bed. Usually they don't write books on bed contamination.
Q. That was going to be my next question. The -- What they're discussing in that book is mold contamination in buildings and walls and things of that nature. Isn't that true?
A. Or things in buildings. I understand in this matter, the bed was in a building. In any event, visible mold contamination confirmed by sampling, which was the case here, is mold contamination. To do air testing just simply doesn't apply, and is either an intentional red herring or a statement by somebody that

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doesn't understand the process.
Q. Let me give you a hypothetical. If I were to soak a beach towel with all the good things that mold liked to eat and zip it up in a plastic bag and allow it to grow mold. And you can see through the plastic bag visible mold contamination, but we know that that mold cannot get outside of the plastic bag, would it still pose a health risk to those standing outside the plastic bag?
A. If it's impermeable, no, it would not. Now, I think it's completely different than the fact scenario in this matter. But to answer your question -- and I think it's more general. If you have a hazard. Say I have this bottle, this plastic battle.
Q. The witness is holding up his plastic water bottle.
A. I'm holding up a plastic water bottle. And this was filled, instead of with water, some very toxic substance, and it's hazardous. But if the substance is contained in this water bottle, it doesn't

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permeate through the bottle, there's no exposure. There may be a hazard. There may be something that you're concerned about. You don't want it to break open. But I'm not going to get sick if I don't have exposure.
So I think that goes to your -- the essence of your question. If you have mold and it's contained, it truly is contained, there's no exposure, then somebody is not going to get sick due to mold exposure. However, I don't believe that refers to the scenario in this matter, and it doesn't, in general, refer to buildings in general. For example, I've had involvement in claims where somebody will say, well, the mold is behind the wall, so nobody should get sick. No, that's -- You can still have exposure through movement of air and the spores from mold behind the wall. And the standard is that you have to remove the mold behind the wall. You just can't paper over it.
Q. So there -- So you would agree with me that if there's mold contamination,

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there must be a path to exposure?
A. You have to -- Yeah, you have to have exposure. That's really a general principal within industrial hygiene and toxicology, that you have to have some path of exposure, which I believe is the case in this matter. Experts on the other side may not agree with that, but I believe that there was exposure.
Q. And one thing that I heard you read from your book there was there's a comparison -- it's helpful to do a comparison between indoor and outdoor concentrations. Isn't it true that often, though the indoor air test done and that compared in the same time of day on the same day to an outdoor concentration, so that one can determine whether or not the level of mold indoors is actually higher than the level of the normal outdoor concentration of mold, and that that is an indication that there's indoor exposure as opposed to outdoor exposure just coming in?
A. Well, as I've testified earlier, if you go into -- and I'm going to

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use -- use buildings for an example, because that's the usual case. It's sort of unusual to have a circumstance where you have a hidden defect as you do in this matter that's a bed. This is sort of an unusual circumstance. But say I go into a building and there's mold growing on the wall. You can see the visible mold and you test it and it is mold. It's not just some dirt, then that's mold contamination. You don't do air testing unless you say, okay, fine, I want to clean this visible mold up. I want to make sure I got rid of it all. Then you could do air testing as clearance testing. But there would be no indication to go forward and say, well, fine, there's visible mold, there's mold contamination, but then let's do air testing. That is done, but it's not properly done. Because why would you do the indoor and outdoor air testing?

Now, back to your specific statement. It's more than just saying there's higher levels indoors or outdoors. You also compare the different species.

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But, in general, you should have the same types of mold and mold species indoors as outdoors, and usually a little bit lower indoors than outdoors.

Did that answer your question, ma'am?

Q. What I'm -- Let's bring this conversation back to causation. If you don't -- If you just see what you claim is mold, according to the literature that you cited, any visible mold outside of the small amount you might see in a shower, is considered or termed mold contamination. How do you rule out other causes of potential mold exposure to an individual that is claiming health effects if you don't do any sort of comparison?

A. Excellent question. Well, the next step is this, and I'm going to give you another reference. Because, you know, it's one thing for me to say as an expert, but another thing because you have experts on the other side saying something different. So how does a finder of fact, how does the judge know what's so? So it's

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good to have external confirmation.

If you go to the Reference Manual of Scientific Evidence, Third Edition, from the Federal Judicial Center and the National Research Council, National Research Council. National Research Council is made up of the National Academies of Science, National Academies of Engineering and Institute of Medicine. It's a joint publication. It's a joint publication meant for judges, primarily federal judges, but also state judges to rule out, to kind of -- I shouldn't say rule out. To assess scientific testimony, qualifications of experts who give scientific testimony, what should be done, proper methodologies. So what one does in a matter like this, because, you know, there's mold -- there's mold everywhere, but there's not mold contamination everywhere. Virtually everywhere that's mold, but there's not mold contamination everywhere. So how does one, as a physician, sort out mold -- whether or not some person is due to mold exposure due to

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some other cause. Well, first off, most doctors are not trained to determine causation of disease. Most doctors are trained to diagnose a disease and treat it, but not to figure out what it is being caused from -- by from some type of occupational and environmental exposure circumstance. There are only three specialties that are specifically trained, and in the normal course of their practice determine causation of disease due to an occupational or environmental exposure circumstance. All three of these specialties are under the American Board of Preventative Medicine. And, by the way, these are the only three specialties to my knowledge that a doctor requires an additional degree beyond a medical degree, M.D., or D.O., in order to sit for the boards. Because you have to have additional training and education beyond what they teach you in medical school to sort out causation of disease due to an occupational and environmental exposure that they don't teach you in medical

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school. And that degree is a Master of Public Health, where you get epidemiology, biostatistics, toxicology, learn a little bit about industrial hygiene, the tools that a doctor needs in order to sort out causation.

Well, those three specialties, first off, are aerospace medicine. Those are the NASA doctors. The NASA doctors have to figure out if there's something about the design of a high-flying aircraft or spacecraft that is causing somebody to become ill --

Q. Excuse me. I don't mean to interrupt you. But we're getting pretty far afield of my question --

A. No, no, no --

Q. -- so if you could get to the point, please.

A. No, no, no. Ma'am, once I start answering, you got to let me finish answering.

Q. You can finish answering. This isn't -- I'm going to have to do additional deposition -- I mean I'm going to have to

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ask the judge for more time if we can't get this done in the three hours that we've agreed to.

A. Ma'am, I just -- Once I start answering, I have to finish, because I have to keep a record. So you're the master of your questions. I'm the master of my answers. So let me continue.

So the aerospace medicine, and this is -- because your question is a complicated question. It is not a simple yes or no. So let me finish, and you will learn something.

Aerospace medicine doctors have to figure out there's something about the design of a high -- that's causing the interior of a high-flying aircraft or spacecraft to get somebody sick. And it's an expensive matter. Because if there is, Boeing, which is right down the street, or North American Rockwell has to redesign that spacecraft or aircraft, and it's going to cost hundreds of millions or billions of dollars. So we want a doctor that actually knows what he's doing. So it's for that

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reason an aerospace medicine doctor has to be able to sort out causation of disease from an occupational or environmental exposure perspective, and that's why they need a Master of Public Health for the degree.

The next specialty is occupational medicine. Those are the guys that are the medical directors of major industrial corporations, or they're the better educated plant doctors. Somebody can come in to the plant physician and say, gee whiz, I have symptoms of shortness of breath, cough, what have you. And a lot of doctors can diagnose asthma and treat asthma, but not many doctors can figure out the cause of that asthma. And it's important for the occupational medicine doctor to know the cause. So, for that reason, the occupational -- because the cause might be the new chemical being used on line five of the plant. And if that's the case, this one individual is the tip of the iceberg of an epidemic of asthma in the plant. So that occupational medicine

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doctor has to be trained and in the normal course of the practice sort out causation of disease due to an occupational or environmental exposure perspective. And, for that reason, an occupational medicine doctor has to have a Master of Public Health to sit for the boards.

The third specialty is public health and general preventative medicine. Those are -- That's the epidemiological and biostatistical specialty within medicine. Those are the CDC hot zone doctors or the medical directors of a major city or state health department. And they have to figure out causation of disease because Patient A may have diarrhea. Is it due to the person having flu, or did they eat at a dirty restaurant? So a public health and general preventative medicine doctor has to be able to sort out causation.

So that's -- Those three specialties -- By the way, I'm board certified in two of those, occupational medicine and public health and general preventative medicine. Those two

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specialties -- pardon me -- those three specialties, two of which I'm boarded in, then what they do is they do something different than the average physician. Most doctors are trained to do a differential diagnosis. That is, person has symptoms: Sinusitis, allergic rhinitis, shortness of breath. Differential diagnosis, what could be causing this? A number of different disease processes, but they rule out the different disease processes and they come to the proper diagnosis such as, in this case with Mr. Ralph Simon, allergic disease. Some allergic exposure is causing his problems. Many doctors, many -- many doctors are trained to do a differential diagnosis. However, not many doctors are trained to do a differential diagnosis of etiology; that is, what are the possible causes from an occupational and environmental medicine perspective? And, by the way, Reference Manual of Scientific Evidence, Third Edition, gets into this around Page 689 of that treatise. And what do you do? Well, you take the history from

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the individual, you see what type of exposures the individual had, when was the onset of the disease process, what may have caused the disease process to get better or resolve? And you consider all the plausible causes for the person's problem, and then you exclude, through a process of elimination, those that would not apply. And then what is left is the -- is the answer to the differential diagnosis of etiology that is the cause of the person's problems.

Q. Is that what you -- the process you went through with Mr. Simon?

A. Yes.

Q. How did you rule out -- Let me back up. What do you do when -- Strike that.

So part of your analysis must necessarily rely on the history that the patient gives you; isn't that right?

A. Yes. But not -- But not solely. I --

Q. Part of it --

A. Part of it. Part of it.

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Q. -- was the question.

And what do you do when the patient doesn't give you an accurate history?

A. Well --

Q. Let me ask you a different question.

Would it affect your diagnosis if the patient does not give you an accurate history?

A. In this case, I don't think there's any question about that. Because I have medical records that corroborate the history that he provided to me. So medical records formulated in the course of his treatment years and years and years before he ever thought about a possible lawsuit against Select Comfort. So the history that he provided was consistent with his medical records that corroborate his history. I can point some of those out to you, if you wish.

Q. Mr. Simon told you that about three or four years after buying the Select Comfort bed he began suffering from a host

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of maladies that he now attributes to the Sleep Number bed?

A. That is in my report. Yes. It says about three or four years after buying the bed, Mr. Simon began suffering recurrent sinusitis, ringing in the ears, a sensation of pressure in the bilateral ears, dry and burning eyes, and skin irritation.

Q. On what date did you first meet Mr. Simon?

A. On the date of my report, which I believe is June the 4th, 2015.

Q. You also note in here that Mr. Simon denies any allergies?

A. That's his statement that denies allergy, yes.

Q. Okay. So he reported to you that he has no allergies?

A. That's what he says. That is a layman telling me -- answering my question concerning allergies. But that's what he said. Now, I don't see any indication that that's any sign of a lack of truthfulness on his part. That's his perception as a

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layman.
Q. So whether or not he truly has allergies, his perception as a layman is that he does not have allergies?
A. Yeah. Because we know he does have allergies because he's allergic to mold, right? Because -- And that's the whole basis of this thing. So his statement of allergies is something that he doesn't feel that he is, in general, an allergic person. It's not something that he feels is part of his general state of health. But we know that he is allergic to mold, because that's the reason why he had the adverse health consequences that led to this issue.
Q. And we know that he's allergic to mold because Dr. Wedner tested him?
A. No. We know he's allergic to -- well, Dr. -- We know he's allergic to mold based upon the temporal onset of his symptomatology, testing confirming that his bed was contaminated with mold, and resolution of his symptoms that would be related to the allergic manifestation of

Page 43

mold after he discovered the mold contamination and no longer was sleeping on a moldy bed. However, Dr. Wedner, I believe, moved forward and also did mold testing that did confirm that he is allergic to mold in addition.
Q. Did you review the skin test chart that Dr. Wedner's office did?
A. I don't recall when I saw that. I do recall having seen such a chart. I don't recall when I saw that, whether I saw that at the time I wrote up this report or not, and it isn't necessary. I was able to make the analysis as an occupational medicine doctor in the manner that I described. Allergy testing isn't necessary because you could test -- for example, somebody could come back with -- that was negative to mold testing and somebody -- so, what, he's not allergic to mold. No, he's not allergic to one or ten or 20 of the 100,000 molds. So that's not -- that's why occupational medicine doctor, particularly one that's trained to deal and does have experience dealing with

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building-related disease, doesn't do it based upon allergy testing. However, you know, give Dr. Wedner my regards for thinking -- thanking him for confirming that he is, in fact, allergic to mold with his testing. Because he is -- That's consistent with my finding and my analysis.
Q. Are you qualified to read the skin chart that was prepared by Dr. Wedner's office?
A. Hand it to me. I'll tell you.
Q. It's -- This is my copy, and I don't --
A. I won't make any marks on it, and I'll give it back to you.
Q. And I don't know that I brought extras. Do you have it in your file? Did you review it?
A. I don't know offhand. I'd have to look. You're interested in making sure this flows quickly, so I want to help you do that.
So I'm looking at this.
MR. CORWIN: For the record, she handed the witness, I'll help you out a

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little bit, handed the witness the skin test results from Dr. Wedner's clinic. Dr. Wedner did not perform these tests.
THE WITNESS: And, well, the first question is, there's some notation here that I've seen skin testing many times. Usually what happens, they'll make little hash marks. Like if there's -- Somebody is not reacting, they'll be blank. And then if somebody has a mild reaction, they'll put one hash mark down. And then if they -- if it's more extreme, they'll put two, and then it'll go on. Or maybe they have a bunch of -- three or four hash marks and they have one through it. That's usually how the mold testing that I've seen, and I've seen these, is recorded in their little handwritten notes. And then what they do is then they'll say based upon, because they did the testing or their technician usually did the testing, that they found that the individual had a skin reaction to the mold.
Now, here looking at this little testing note, they'll have different

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numbers. Like maple, red maple, there's a one. Oak mix, two. Somebody wrote Bermuda grass, three. Rag weed mix, four; Alternaria, which is mold, is a mold. Again, let's see, there's panel. Panel 4 mold, okay. There's Panel 5 mold two. Then there's Panel 6. These are -- There are three panels for mold that have in each panel about eight. So --

BY MS. FISHER:

Q. So --

A. Let me finish, ma'am. So we have maybe about less than 24 molds, about 24 molds out of the 100,000 molds. And on this one they say Alternaria, 5; aspergillins, 6; fumigatus, 7; cladosporium. Cladosporium is the one we're concerned about as far as testing that was shown in this mattress, 8. Fusarium, 9. So that's an indication to me that with this notation that the skin reactions were more extreme. Two more extreme than one, three more extreme than two, four more extreme than three, five more extreme than four.

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So that's how I would interpret this from looking at the chicken scratch on that report.

Q. Okay. So did you review at one point Dr. Wedner's report in which he listed out the items that Mr. Simon was sensitized to?

A. I did read his -- I did read his report. I don't have -- I think it was a report, and then there was a rebuttal report to my report. I don't have a photographic review of it. If you want to draw my attention to the report and have me comment upon it, you have to show it to me again and I'll look at it again.

Q. Well, let me just -- I'll just refresh your memory that the report indicated that Mr. Simon was a highly atopic individual allergic, or at least sensitized, to multiple different things. Do you recall that?

A. I won't differ with your assertion that that's what it says at this moment.

Q. With respect to Mr. Simon

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having what's considered an allergic reaction, did you do anything to rule out symptoms related to allergies to other substances besides mold?

A. Yes.

Q. What did do you?

A. The history from him and review of the records. He was in -- Well, in his normal state of health as it would relate to any allergic manifestation of disease until first record of this. Let me back up for a second.

We have Dr. Spiro's records. I believe it's Thomas Spiro, who was his internal medicine doctor. And I, in addition to being board certified in occupational medicine and public health and general preventative medicine, I'm also an internal medicine doctor.

And I have a note from Dr. Spiro from July 16, 1999, that in the systematic review, in essence, I'm not seeing anything here that has to do with any indication of sinusitis, skin rash, rhinitis, or shortness of breath or cough.

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No phlegm production, night sweats, hemoptysis, or cough. No pain or inflammation of the eyes or swelling of the eyelids. Ears, no ringing in the ears or discharge from the ear canal. Denies history of headache or trauma to the head. No history of dyspnea. That's shortness of breath on exertion. And some history of palpitations.

So from an allergic standpoint, his allergic manifestations of disease, July 16, 1999, he's fine.

By the way, long before he's really -- I think that at the time of either before or shortly after he bought the Select Care bed.

Q. In order to make --

A. Let me finish, ma'am.

Then we have a history, a note, from Dr. Spiro, October the 8th, 2002, where Mr. Ralph Simon presents with -- presents for physical exam. Patient today complains of nasal stuffiness and shortness of breath at night, at night is when he's having it. And then the records go on

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where he's having rhinitis and the like. So we have documentation that he was not having these allergic problems before the issue with the bed. They developed. And then they resolved after he had discovered -- largely resolved, not completely resolved, after he discovered the mold contamination of his bed, and then stopped sleeping on the mold-contaminated bed. So that allows me to have ruled out some other allergic manifestation as the cause of his problems. Why? Well, if he's atopic, he's probably atopic his entire life. When he's living in St. Louis, if he has problems with cladosporium or mold in the air, he's been living with that for years. And he's still living in that environment in St. Louis, the general air environment. It went away. I'm not aware of any assertion that somehow he had some change in his diet that was consistent and accordant with that time duration of his symptomatology with the bed. I'm not aware of any other exposure circumstance that matches the temporal sequence of his

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symptomatology other than the bed. So that light leads me to the recognized methodology utilized by occupational medicine doctors as enumerated in the Reference Manual of Scientific Evidence, Third Edition, to say, yes, the cause was the bed.

Q. What did you do to rule out dust mites?

A. Dust mites would have been part of his environment before the bed. I mean he's been sleeping on beds. There's dust mites in beds. There's bust mites in beds after the fact. So how did the rule change relating to dust mites before and after the time duration that he's sleeping on this moldy bed from Select Care. It's just --

MR. CORWIN: Comfort.

THE WITNESS: Select Comfort. That's an exposure that he had before, during, and after. But his symptomatology matches his duration of sleeping on the moldy bed.

BY MS. FISHER:

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Q. What facts in the record are you relying on to show you that there was mold in the bed in 2002?

A. First off, there was no testing in 2002 because he didn't know about it. That's part of the problem with this whole thing. We have the fact that he bought the bed some period of time beforehand, I think 1999. That would have given ample time for mold to have developed in the bed due to the design defect of Select Comfort, that specifically the impermeable barrier that would lead to accumulation of liquid water and mold growth. And then we have the later discovery of the mold, I think, sometime in 2012. So the deductive logic analysis is that there was mold contamination there during the relevant time period. Because it would have given enough time for mold to have developed, and there's no fact scenario that I'm aware of that would say that the mold contamination that was discovered in around the 2012/2013 time period suddenly, acutely developed because there was some water intrusion into

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the home or water intrusion into the mattress. There's -- I'm not aware of any fact scenario consistent with that.

Q. So your opinion is based, at least in part, on an assumption of mold in the mattress in 2002?

A. I wouldn't say an assumption of mold in the mattress. It's based upon the facts in this matter. There was mold contamination found documented when he discovered the mold. He had it -- It was tested. It was contaminated with cladosporium. And he was sleeping on the mattress. The mattress has an impermeable barrier in the form of its bladder, air bladder, that led mold contamination to happen is what I, given my expertise, would expect to happen, and would give enough time for that to happen.

And, by the way, when I talk about that air bladder happening, I'm going to also, so that you're not surprised at trial, I'm also a biomedical engineer, besides being a physician. And biomedical engineering has to do -- part of it would

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have to do with design of medical equipment, including -- and also beds. And I am more familiar with beds than most physicians. Because I have, through my career, been called upon to deal with the care of catastrophic injury patients, quadriplegics that would be susceptible to bed sores. So I'm familiar -- I'm more familiar than the average physician with beds, the properties of beds, and, particularly, the properties of beds as a biomedical engineer. That, in addition as an industrial hygienist, I know the circumstances that would lead to mold accumulation due to vapor intrusions. In this case, the vapor intrusion was perspiration, vapor arising from his bed, from his body, lying upon his bed permeating through the sheets, permeating down into the padding of the bed, and then hitting an impermeable barrier, the bladder of the Select Comfort bed, forming liquid water and developing mold. That is the scenario that would happen in a building if you're in an area that is a warm area where

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individuals have air conditioning, where you have vapor intrusions coming in through walls. Because, you know, brick walls, this building, brick still has vapor intrusions coming in through the wall. Brick and mortar doesn't keep water from going through walls. And then the water will follow its radiant down until it hits an impermeable barrier. And that's why you're supposed to be careful and not put vinyl wallpaper upon the interior walls of buildings that are cold in a warm environment. And the reference to that that's, that supports my assertion is out of Bioaerosols: Assessment and Control, 10.4.3.2, Condensation Control in Hot and Humid Climates.

Q. Are you intending to opine on the defective nature of the bed at trial?

A. I'm intending to opine to all my relevant areas of expertise if called upon to do that. That would include the defect of the bed, because I am qualified as a biomedical engineer, I believe, to testify to that. Now, I may not be the

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sole expert testifying upon that. And it may not -- I may not be called upon to testify to that. That will be Mr. Corwin's decision. But I do believe that I am qualified as a graduate biomedical engineer and a physician, along with my other expertise, to comment upon the design defect of the bed, yes.

Q. You mentioned that it would give ample time from the purchase of -- Mr. Simon's purchase of the bed several years later for mold to have grown. How long does it take mold to start growing?

A. Mold can start growing very rapidly, within a matter of -- if you have the right circumstances, within a matter of a couple days.

Q. When you locate mold, is it possible for you to determine how long mold has been there?

A. If I have sufficient additional information such as I have in this case, yes.

Q. Do you know the date at which -- when the foam padding on

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Mr. Simon's bed was tested?

A. I don't know as I'm sitting here at the moment. I don't have these records memorized. I mean so if you're asking me the specific date, no, not at this moment. If I looked through records and if you want me to take the time to do that, I can start trying to look through records to try to find that.

Q. It's not --

A. But I don't have that memorized, no.

Q. It's not necessary. If mold was, indeed, tested and found, at least according to Ms. Duncan on a bed four months after Mr. Simon ceased using the bed, isn't it true that all that test shows is that mold was present on the bed on the day of the test?

A. No.

Q. That is not what that test shows?

A. I don't think so. The test is a snapshot, but the test is not the void or absent of the history and information. So

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I believe I have sufficient information to say that that mold developed over time, and that his symptomatology where he -- where there's a medical record indicating his seeking medical attention for a disease, allergic disease, mediated due to his mold exposure in the bed, that he sought medical attention on October the 8th, 2002.

Q. Do you have any idea how the -- how the foam that was in the bed was stored in the intervening time period between Mr. Simon's alleged discovery and the date that it was tested?

A. I have no indication that it was stored in a scenario or circumstance that would lead to any spoilage of the -- of the sample. If you have some information that you think it was somehow spoiled, let me know, and I may alter my opinion. But I'm -- but I'm operating under the understanding that it was stored in a manner that the visible mold contamination that he saw when he opened up the bed and found that hidden defect is representative of the visible mold

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contamination that was confirmed with testing by Ms. Duncan four months later.

But if there's something that you think would lead -- that you think it was somehow spoiled, led to mold growth in the interval, let me know. I'm not aware of any -- of any unique circumstance, but perhaps you are.

Q. If, indeed, it -- If, indeed, there was a circumstance that could have led to mold growth in the intervening period, would that change your opinion?

A. Tell me what the circumstance is, otherwise you cause me to speculate. It's caused -- Your asked question calls for speculation.

Q. Let me ask you a different question.

Are you of the opinion that Mr. Simon is sufficiently qualified to identify mold contamination visually?

A. I think people in general have seen mold. I don't think it's unique for people to have looked at and see this looks like mold, and then for him to have called

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upon somebody to do the testing which, in fact, confirmed that it's mold. So I see nothing about Mr. Simon that would make him any less qualified as a layman to look at a circumstance and have strong suspicion that it's mold. And I believe that's what happened in this matter. And then it was, in fact, confirmed that it was mold based upon the testing.

Q. Would you agree with me, though, that the testing to be the most accurate should have been confirmed immediately? Should have been performed so that mold could have been confirmed immediately on discovery?

A. No, no. I mean are you saying that this is some type of -- there's something about mold that if you don't capture it at that moment that the results are going to be different? Now that's true with different types of toxin exposures, like carbon monoxide. If you went into -- By the way, I am a toxicologist. It's not just me saying that. If you go to the Reference Manual of Scientific Evidence,

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Third Edition, on about Page 675, I qualify in a number of points to be a toxicologist, and I deal with toxicologic issues very commonly.

For example, if somebody has carbon monoxide exposure and they get exposed to carbon monoxide, if they go to the hospital very rapidly, then a carboxyhemoglobin level can be drawn, and that would document the level of carboxyhemoglobin close to the time of the exposure. If you wait a day, even a number of hours that -- you're going to lose that information. That's not the case with mold.

So, in this circumstance, I -- Unless you have some unique -- if you have some circumstance that would lead to spoilage, the fact that the mold is sitting there four months later and tested after the initial discovery, that doesn't question me -- lead me to question the results. And, in fact, that's very commonly the case in buildings. Somebody sees mold and it's not tested until four

Page 62

months later, that, given the circumstances and findings, doesn't say, oh, that mold grew in the meantime. It could have, if you can give indication that it would have. But the fact that the testing is done four months later doesn't -- doesn't nullify the analysis. If somebody is saying something different, I believe that they are not making a statement that would be generally accepted in the relevant industrial hygiene and medical community. And I would say that they should come up with some peer-reviewed literature that would corroborate their statements. Because I think it would be junk science.

Q. You just did confirm, though, that mold can grow within a couple days?

A. I did. But tell me the circumstances that you think happened here that caused this mold to grow in the pattern that is found on his bed consistent with perspiration coming in from the body. In fact, maybe an analogy can be made, it looks almost a little bit like the Shroud of Turin. The mold is where you would

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expect the perspiration to come. Give me the circumstance that you think created that other than the vapor intrusions --

(Interruption in deposition.)

MR. CORWIN: Is this something you need to take?

THE WITNESS: No. The vapor intrusions from the -- from somebody sleeping on the bed and having mold accumulate due to the design defect of the bed and the failure of warning -- By the way, I think I have expertise concerning warnings, being an occupational medicine doctor.

MS. FISHER: No doubt you do.

THE WITNESS: And industrial hygienist to warn him to be able to look for mold, be concerned about this as a possibility so that he could then inform his doctors -- discover the mold and then inform the doctors that are treating him for his symptomatology so that they would be aware and avoid adverse health effects that happen to him due to the doctors not

Page 64

knowing about the mold. Because I believe in this circumstance his doctors did not know, nor should they have been aware, of the mold given the circumstances because it was a hidden defect in the bed.

Q. You know what, I'm going to backtrack a little bit and take care of some generalities before we run out of time. When were you first contacted for this case?

A. Yes, ma'am. I don't recall. It was obviously sometime before June the 4th, 2015. How long before that, I don't know. I don't think it was years before. Probably a matter of a few months, but I don't have a present recollection.

Q. Do you recall who contacted you?

A. I believe Mr. Corwin.

Q. What was the scope of the request?

A. Well, I don't have a present, you know, recollection of the request in any detail, but I think he probably told me the fact scenario. And I told them, well,

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listen, these are -- This is my area of expertise, these are my -- the areas that I can address. These are my charges. Obviously I don't know what my opinion is going to be until I've done my analysis. I told him that my charge is $30,000 for the review of the records, preparation, really everything other than travel time, waiting around time, and testimony time. But that, you know, I don't know what my opinion is until I see it. And if my opinion is in favor of you and you wish me to write the report, I keep the $30,000. If my opinion is not in favor of your situation, I will give back the $30,000. That's, in essence, what I believe I told him. And then he contacted me some period thereafter to say, yes, I wish you to go forward with the process, sent me -- I believe he sent me records to look at initially. And then I said, well, this looks like I may be able to be favorable, and then I did my examination of Mr. Simon and formulated my opinion and then report.

Q. I'm going to hand you a copy of

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your report in case you don't have it right in front of you.
(Document marked as Dr. Chiodo Exhibit No. 2 for identification.)
BY MS. FISHER:
Q. Is that the report, the initial report, that you wrote in this case?
A. It looks like it. Yes, ma'am.
Q. Take your time if you need more time.
A. Yeah. I -- It looks like my report.
Q. Are all the documents that you reviewed listed under -- on Page 2 under records reviewed?
A. As of the date of my report. Not necessarily all the records I subsequently reviewed.
Q. Okay. What --
A. What I call the records may be something different than what you're calling the records or Mr. Corwin may call the records. But this is my enumeration of what I call the records as of the date that

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I wrote my report.
Q. After, subsequent to the time you wrote your report, are there additional records that you've reviewed?
A. Yes.
Q. Can you --
A. But I don't have an enumeration of those.
Q. Can you tell me what they are?
A. Well, not with -- I mean I can tell you in general I believe I reviewed the reports from your experts and rebuttal reports. I don't know if I -- I can't recall whether I reviewed deposition testimony or not. Mr. Corwin knows what he sent me, but I don't have an enumeration of that.
Q. Did you ever review the deposition testimony of Mr. Ralph Simon?
A. I don't recall as I'm sitting here today.
Q. Does the report contain all the opinions that you originally were requested to provide an opinion on and testimony on?
MR. CORWIN: Objection. Calls

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for -- What was your objection at the first depo we did? Confidential or privileged discussions. Subject to that, you can go ahead and answer. I think it's also vague as called for, but --
THE WITNESS: Yeah. I mean there are my opinions that I have at that time. Whether I'm going to be called upon to render additional opinions within my relevant areas of expertise, I don't know. And there may be opinions that come up due to your questioning, cross-examination at trial that I may not anticipate. So I don't necessarily anticipate all the questions that Mr. Corwin is going to ask me on direct examination that would get into my analysis concerning this circumstance utilizing my areas of expertise. Nor can I say -- So, therefore, the report is not necessarily limited to that. I'm not saying that this is the totality of all possible opinions. I think it is the central focus of my opinions in this matter. But you may also ask me questions on cross-examination that will

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elicit answers and opinions that are not enumerated in this report.
BY MS. FISHER:
Q. So on Page 1 I see your qualifications to opine, and it goes on to Page 2. And I understand that you also a CV which we've got here marked as Exhibit 1. I just want to just make clear a couple things. You don't have any continuing education or you're not board certified in allergy or immunology, correct?
A. No. I am board certified in general internal medicine. Allergy and immunology is an internal medicine subspecialty. So I do have training, board certification, recertification, and also additional recertification in general internal medicine that includes allergy and immunology. But I am not board certified in the subspecialty of allergy and immunology. But that's -- But I am not devoid of knowledge and expertise concerning allergy and immunology. And that, of course, I have additional

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expertise being board certified in occupational medicine. The actual board certification certificate says occupational medicine, and it's typically referred to as occupational environmental medicine which deals with allergic issues in this context with mold. In fact, that's usually the central expert, and also the central clinician sorting out mold exposure issues in this matter, whether or not the disease was caused by a building-related issue. And then also additional expertise as far as epidemiology and biostatistics that would call upon allergic-mediated disease through my board certification in public health and general preventative medicine.

And, of course, I'm one of the few physicians, really in the world, that is a certified industrial hygienist. There's 6,600 certified industrial hygienists in the world. Only about 5 to 10 of them are physicians, to the best of my knowledge. And I have some stature in that profession in that I'm one of the past presidents of the Michigan Industrial

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Hygiene Society, which was the first industrial hygiene organization in the country.

So I would disagree with your assertion that I don't have knowledge, training, and continuing education concerning allergy and immunology. And, in fact, I happen to have brought along me today, not for this deposition, just because when I'm on the plane I read, the American College of Physicians Medical Knowledge Self-Assessment Program 17. Now this one happens to be on cardiovascular medicine. But one of the monographs on 16, which I completed within the last year or two, was on allergy and immunology. So I keep up on the relevant discipline.

Q. Are you trained in any special way in the discipline of ophthalmology?

A. I don't consider myself an ophthalmologist, but I am trained concerning toxicologic effects due to substances, including drugs. So as to the issue of cataracts caused by corticosteroids, Prednisone is a

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corticosteroid. I believe that not only am I qualified as an internal medicine doctor, because internal medicine doctors are very commonly the type of doctors that would order corticosteroids, including Prednisone, and must know about the toxicity. I am also a toxicologist. Again, if you -- not just a matter of myself proclaiming such. If you go to the Reference Manual of Scientific Evidence, Third Edition, on or about Page 675 I meet the qualifications on at least three points of being a toxicologist. So I am an expert concerning the toxicologic effects of drugs and other substances as they relate to the eye. But I'm not an ophthalmologist. And, likewise, I don't think just because somebody is an ophthalmologist they're necessarily qualified to opine about the toxicologic effects of substances as it may relate to eyes. They're obviously qualified in general about eyes, but not -- that doesn't make them a toxicologist.

Q. How about an otorhinolaryngologist. I'm going to

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butcher it. An ENT?

A. ENT. That's good.

Q. We'll do that.

A. That's good enough. Again, I'm not an ears, nose, and throat doctor, an otorhinolaryngologist. But, again, the issues of the toxicologic effects of substances as it relates to the ears, nose, and throat, as to the allergic consequences of exposures as well within my expertise. That's why there are general internal medicine doctors. General internal medicine is actually a very broad specialty. You have to probably know more and stay current on -- concerning more issues as a general internist than any other specialty. Ophthalmology, you have the benefit that you can just -- entire focus in life can be focus canned just on eyes. As a general internal medicine doctor, you have to know about hearts, you have to know about kidneys, you have to know about lungs, you have to know about ears, nose, and throat. You have to know about dermatology and neurology. It's a

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very broad specialty that you have to know and be very conversant in broad specialty in that you have to have an in-depth knowledge, unlike family practice, where it is a much more superficial knowledge than a board certified general internal medicine doctor.

Q. You are of the opinion that Mr. Simon's cataracts are due to Prednisone?

A. Yes, ma'am.

Q. And you cite a -- You cite a study or you cite some literature, steroids, including Prednisone, are well known to cause cataracts?

A. Yes.

Q. Or, actually, that's your statement. The literature that you cite is Steroid Cataract. Is that the literature you're basing your opinion on?

A. No, not solely. That's literature. Also I brought with me today the Merck Manual, 19th Edition, copyright 2011, Page 606 and 607. Cataracts. Talks about etiology of cataracts, okay. And it

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says etiology, cataracts can occur with aging. Other risk factors may include the following: Trauma, sometimes causing cataracts years later. Smoking, alcohol use, exposure to x-rays, heat from infrared exposure, systemic disease; e.g., diabetes. Uveitis, which is like inflammation of part of the eye. Systemic drugs; e.g., corticosteroids, undernutrition, dark eyes, possibly chronic ultraviolet exposure. Many people have no risk factors other than age. Some cataracts are congenital associated with numerous syndromes and diseases.

In fact, it continues on. This is actually a good couple pages --

Q. I really don't want you to read a couple pages.

A. No, ma'am. I'm not going to read the pages. But I do have to complete my answer.

And then at the bottom of 607, prevention. Many ophthalmologists recommend ultraviolet-coated eyeglasses or sunglasses as a preventive measure.

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Reduced risk factors such as alcohol, tobacco, and corticosteroids and controlling blood glucose in diabetes delays onset.

Now, nothing in this treatise that I saw said that cataracts, due to steroids, are solely postocular lenticular cataracts as Dr. Shear asserts. So maybe he's confused the initial study that I -- This is the early study that talked about cataracts, mentioned that they were posterior subcapsular lens opacities. However, to my knowledge, the risk of corticosteroids applies in general to cataracts.

Now, if he somehow thinks I'm different, I'll let him support his opinion with whatever he thinks. But as to my opinion, I believe my opinion is supported by the literature that I cite. And that in light of Dr. Shear's claim, I brought along the Merck Manual, 19th edition, and I believe that the risk to cataract applies not solely to just subcapsular cataracts from corticosteroids, but to cataracts in

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general. That combined with the fact that usually cataracts will develop in individuals in their 60s or 70s. That's when you really start having manifestation. And then Mr. Simons developed his cataracts at a very young age. That leads me to believe that the cataracts were caused by, at least in part, by his prescription of Prednisone, a corticosteroid, due to the lack of knowledge of his physicians that he was sleeping on a moldy bed. I'm not criticizing his physicians at all. There's no criticism on my part of any of his physicians, his treating physicians. But that his cataracts were caused by, at least in part, if not solely, due to Prednisone. And, again, I've just provided you the literature cite that I believe corroborates my opinion.

Q. So the literature that you are -- Do you need to take a break?

MR. CORWIN: Yeah.

MS. FISHER: Okay. Can I just --

MR. CORWIN: Finish your

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thought.
MS. FISHER: If the witness can keep the answers confined and --
MR. CORWIN: He's doing the best he can. Mr. Carlson, I had similar problems with him -- not Carlson. Hemmings. But --
MS. FISHER: So let me just ask the next question on this line and then we'll take a break.
MR. CORWIN: Sure. Okay.
BY MS. FISHER:
Q. And I'm going to give you -- So the question is --
A. I can't promise a short answer, so maybe we should just take a break now.
Q. The question is you're relying on the literature that you cited and the book you just read from, and those are your sources?
A. Well, and my knowledge, training, and experience. These are just corroborating what I know.
Q. Okay.
A. I mean Dr. Shear can say he

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knows certain things because he's been an ophthalmologist for however long. I know certain things based upon my knowledge, training, and experience. So the literature cites are not the basis of my opinion. They corroborate my opinion based upon my knowledge, training, and experience.
Q. Why don't we take a break. Go off the record.
(Short break taken.)
BY MS. FISHER:
Q. I'm going to have the court* reporter mark the next exhibit as Exhibit 3.
(Document marked as Dr. Chiodo Exhibit No. 3 for identification.)
BY MS. FISHER:
Q. This is the article that you referenced in your opinion, isn't it?
A. Yes. Well, that I referenced in my report.
Q. I'm sorry. In your report.
A. Also reference is another

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treatise, the Merck Manual, as I'm sitting here today because of the assertion brought up by Dr. Shear.
Q. So you don't -- You don't disagree with -- You don't agree with the assertion in this article, at least, that the type of steroids that was seen in the study that was referenced in this article entitled Steroid Cataract was a posterior subcapsular cataract?
A. Yeah. My understanding from briefly looking at this again; again, it's been some time since I've reviewed this and written my report. So to be quizzed about it, I'd have to read it again. However, that being said, it's my understanding is that from just looking at the beginning of it, they found individuals with subcapsular -- posterior subcapsular lens opacities in 25 steroid-treated group. And five in the nonsteroid group. So that this is a study that I believe was one of the early studies that said, oh, steroids can cause cataracts. Now, I think it's a misinterpretation to say that, oh, you

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know, only -- steroids only cause posterior subcapsular cataracts. No. Steroids are a risk for cataracts in general. And Dr. Shear's assertion that they're not a -- that they're not a source of risk for development of cataracts in general is inconsistent with what I just read to you from the Merck Manual. So the --
Q. So the Merck Manual is your reference that steroid-related cataracts go beyond and have been found other than in posterior subcapsular cataracts?
A. Yeah. Again, you look at the Merck Manual. They talk about the risk of cataracts. One of the risk factors for cataracts is corticosteroids. That includes Prednisone. They don't say one of the risk factors for just posterior subcapsular cataracts, as Dr. Shear is asserting. They say at risk for cataracts. Now, I'll leave him to support his opinion with literature that says that I'm wrong in my opinion and my understanding. I've just cited literature that I believe corroborates my opinion, okay? If he

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thinks I'm wrong, then he can come up with his literature that he thinks supports his assertion that I'm wrong. But I believe this Merck Manual corroborates my assertion and my knowledge based upon my training, education, and experience that corticosteroids, including Prednisone, are a risk factor for cataracts. Cataracts in general, cataracts as they relate to Mr. Simon. But if Dr. Shear thinks that he has some specialized knowledge that he's going to oppose mine, I'll leave him to render his opinion and come up with literature that shows that what he's saying is not just -- is not junk science and meet his Daubert requirements.

Q. Would you turn to Page 365 on the article. In the left-hand column about a little more than three-quarters of the way down there's a paragraph that starts, Before Diagnosis.

A. Bear with me for a second. Now, by the way, if you want me to refer -- Let me put this as a general statement. You're going through and referring me to

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certain lines in this document that I have not read since June the 4th, 2015, the date of my report. Now this is now August the 20th, 2015. So you may be cherry-picking sections of that. And I won't -- to quiz me at it or to have me comment upon the implication of any writing upon this, I have to reread the entire document to see if what you're reading is being taken out of context. With that being said, if you want to address my attention to something and see if you correctly read what you're about to read, I'd be happy to do that. But for me to comment and say that that represents the total impact of this paper, let alone the underlying question, I'd have to reread this article. So that being said, I'm at your service.

Q. Let me direct your attention to the paragraph that starts before diagnosis.

A. Right.

Q. Would you just generally agree with the statement that before a diagnosis of steroid cataract can be made, other causes of posterior subcapsular opacities

Page 84

have to be considered; e.g., familial, traumatic, complicated, toxic, radiational, and senile. Would you agree with that statement?

A. I think I generally agree with the assertion that if you're talking to -- as to causation, you need to do a differential diagnosis of etiology. And I'm not aware of any risk factor that would have produced the combination of problems that Mr. Simon has suffered other than his exposure to mold in the form of his bed and his -- and the consequences of that including chronic sinusitis, and his treatment with steroids. So I'm not aware of any combination, any other cause that would explain that combination or presentation on his part.

So, yes, I believe that you have to do a differential diagnosis of etiology, and I'm the one that referenced you to the Reference Manual of Scientific Evidence, Third Edition, on or about, I believe it was 6 -- Page 686. So I do, in general, agree with that.

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Q. And you have ruled out hereditary familial cataracts for Mr. Simon?

A. I'm not aware that -- I'm not aware, as I say, testimony, as I've said, cause, if not the sole cause. Somebody could have some genetic component that make them particularly susceptible. That doesn't mean that they have a target painted upon them. And that means that cause, if not the sole cause. So one -- It is very rare to have cataracts at a young age -- It's rare to have cataracts at a young age. If you have some information that says otherwise in the case of Mr. Simon, that there's some rare genetic defect that he has that caused him to have early cataracts, fine. Thank you. I'd be interested in hearing that.

And then the next question is, okay, fine, so he's -- If that's the case, then he's susceptible to cataracts and then you have another exposure that's going to make him have another risk factor for cataracts. That doesn't nullify the

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causation analysis. The only factor that that would include would be caused by, if not solely, by cataracts. And, by the way, that was my testimony. If you go back in my -- to the transcript before you begin asking this line of questioning, I said that I believe that his cataracts were caused by, if not solely caused by, corticosteroids.

Q. Are you familiar with the lens opacity grading system -- I'm sorry -- classification system.

A. Not as I'm sitting here at this moment. I can go back and look that up if that -- if that were germane to this issue, I would be. But I'm -- I'm not aware that it is germane. I know that he has cataracts, he's been diagnosed with cataracts. And what grade he is on cataracts doesn't impact the causal analysis, from my perspective. Maybe Dr. Shear thinks so. And I'll let him explain why he thinks so, if, in fact, that's what he thinks. Because obviously you're not testifying. You have to have

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some expert testify. I anticipate he's going to be the expert testifying on the issue. I'll let him explain why the grading of the cataracts would be relevant to his analysis contrary to mine.

Q. Did you do any analysis with respect to the dosing of the Prednisone that Mr. Simon received?

A. My understanding is he was on Prednisone for some significant period of time. And that there is not -- You know, dose response is a sigmoidal curve typically. Some people can develop an adverse consequence at a low dose, and some people can develop it at a high dose. My understanding that this was not a single one-time dose; that this was somewhat of a chronic medication. If I'm incorrect, let me know. And that consequently there would have been sufficient dose to have caused the adverse effects, dose and duration to cause the adverse effects. And that's me testifying not solely as a physician, but as a physician and a toxicologist as the qualifications of being a toxicologist

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enumerated in the Reference Manual of Scientific Evidence, Third Edition, on or about Page 675.

Q. So have you actually seen the evidence that would allow you to determine how large of doses, how many, and for what length of time Mr. Simon actually physically received Prednisone?

A. I have his medical records. I reviewed them. I don't have them memorized. If you're asking me to enumerate what doses, when he took or whatever, I can't -- I'd have to go back through it. I'd be happy to do that if you want to start using your remaining deposition time for me to go through that exercise. I can merely state that's my understanding that he had a somewhat prolonged course of steroids due to his manifestation of disease. And, quite frankly, they couldn't figure out what was causing his problem in that it is not necessary in the analysis nor do I believe that it would be generally accepted that I have to know exactly what day he started --

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Although we can work this out from the records in the exact amount of dose. Because toxicity is a sigmoidal curve. Some people are susceptible at a low level. Some people are susceptible at a high level. It tends to be a sigmoidal curve. And that really doesn't get, in this context, into the causation analysis. It just means if you're claiming that he has some type of hereditary predisposition, that you got the eggshell plaintiff. That's all it means.

Q. Let's move to -- Well, I'm sorry. Before I -- Are you aware of Mr. Simon taking Prednisone for any other reason other than what he alleges was mold-related allergies?

A. You know, again, you're asking me to go back and through the medical -- the question that you want me to go back through the medical records. I'll start leafing through this, these medical records.

Q. No. Just as you sit here today, do you recall seeing that for any

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other reason?
A. I, again, I don't have these records that are probably the size of a fairly good metropolis phonebook memorized. If you want me to answer a specific question to that issue, I have to go back through them. If you want to reference me to some issue that you think is relevant, then I'm happy to tell you whether I think that affects my opinion or not. But I don't have that type of recall. You know, I am a pretty well-educated guy. People think I have a better memory than I have. I don't have that type of photographic memory.
Q. All right. Let's move to another topic. Let me give you another.
(Document marked as Dr. Chiodo Exhibit No. 4 for identification.)
THE WITNESS: Again, if you're going to quiz me about the specifics of it, I'd have to reread it. I offered this as an assertion that the well-known fact among -- that I knew based upon my training

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and experience probably going all the way back to my days in medical school that aminoglycosides are ototoxic. So if you want to address me to a specific point in this article other than my use of this article just corroborating my opinion based upon my knowledge, training, and experience, then I'd have to reread the article to answer, you know, to answer any type of quiz.
Q. The first question is, you referenced this article in your opinion, correct?
A. Yes.
Q. And you rely on this article in your opinion, correct?
A. No, no, no.
Q. You don't rely on this article in your opinion?
A. Ma'am, my opinion is based upon my knowledge, training, and experience. I don't rely upon this. I knew this -- I knew that aminoglycosides were ototoxic back when I was a medical student back in the early 1980s. What this article does is

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corroborate my opinion. Why am I doing that? Because it's federal court. It's Daubert. If I have to offer an opinion, I, just like your experts, are supposed to corroborate their opinion with citations from the peer-reviewed literature. But I don't rely upon this. This is -- I've known about the ototoxicity of aminoglycosides since sometime in the either late 1970s or early '80s when I was a medical student.
Q. And that knowledge was based on what you learned in medical school, correct?
A. Medical school, residency. I mean it's just -- It's just known. Aminoglycosides are ototoxic. If somebody is saying something different, then they're saying -- then it's -- I think that's inconsistent with what would be generally accepted. But this article is just an article that corroborates that opinion. Why do I include it? Daubert. That's what's required in federal court.
Q. Can you direct me to any other

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peer-reviewed literature?
A. Okay. I'll get out my iPhone and I'll start doing a literature search.
Q. No. If you know some off the top of your head, you can point some out. My question about this article is with respect to the delivery method and dosage of gentamycin. Are you aware of any differences in delivery methods and dosage of gentamycin which would produce a potential ototoxicity result? Or is it any drop delivered in any manner?
A. It depends -- Again, obviously you have to have -- the aminoglycoside have contact with the relevant neural structures within the ear to cause the ototoxicity, which is essentially a deafness and also tinnitus. So you can have that happen via IV infusion, you can have that happen with topical application, with absorption, or with diffusion. I'm not aware that there's a limitation to the method. I'm not aware that topical drops do not have ototoxicity. That is not my understanding. Now, if somebody has a contrary opinion, I'll leave

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it to them to explain why and have literature that supports their opinion. I believe that this literature corroborates my opinion.

Q. I believe earlier you said you didn't fault any of Mr. Simon's treating physicians?

A. I don't fault any of them. I do not.

Q. Are you aware that his ENT treating physician was aware of his hearing loss and prescribed the gentamycin anyway?

A. Yeah. I'm not -- I'm not faulting him. He was put into a very difficult treatment dilemma that if he had known about the mold contamination of the bed, he would not have been put into that difficult circumstance. You know, drugs are used, some drugs are used even if they are going to cause toxicity, because you have no choice. And I am not faulting the treating otolaryngologist in his clinical decision that, yes, you know, I'd rather not use something that is ototoxic in somebody that has some preexisting hearing

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loss, but he's painted into a corner. So I'm not faulting him. Now, if you have somebody, one of your doctors that wants to fault him, that's their business. But I -- I am not faulting him. He was put into a difficult diagnostic -- diagnostic and treatment dilemma because of the hidden defect of the Select Comfort bed.

Q. Are you aware that he testified in his deposition that he didn't believe that the delivery method and amount that Mr. Ralph Simon received of this particular drug would have any bearing on his hearing at all?

A. I understand that. The next question is, is he a toxicologist? Because we're talking about ototoxicity. Toxicity means toxicology. So I'm a toxicologist. He's not. So, you know, he deals with ears, nose, and throat. You would think that an ears, nose, and throat would know everything about ears, nose, and throat, but no. If they're not a toxicologist, then I would say that he's not qualified to give that toxicologic opinion. But I am.

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And you don't just have to take my word for it. You can go to the Reference Manual of Scientific Evidence, Third Edition, on or about Page 675. I'm a toxicologist. I'm qualified to talk about toxicity including ototoxicity. He's an ear, nose, and throat doctor. I find no reason to believe that he's anything other than a very fine ears, nose, and throat doctor. But he's not a toxicologist. And I think he's -- if -- I think he's wrong if he's making an assertion on the toxicologic issues other than what I'm saying.

Q. How much time did you spend with Mr. Simon when you performed his examination?

A. Maybe an hour, hour and a half. I don't have an exact recall.

Q. I'm going to hand you a new exhibit that we're going to mark as No. 5.

(Document marked as Dr. Chiodo Exhibit No. 5 for identification.)

BY MS. FISHER:

Q. This is not something I'm

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certain you've seen before, so I want to give you some time.

A. Okay. Then you want me to read it. I'll read the whole thing. I have to read the whole thing, so that will take some time.

Q. My first question is, have you ever seen the article before? Are you familiar with it at all?

A. I don't recall. I mean if you want me to comment upon an article that I -- I have to read the -- Obviously I have to read the whole article. And I'll tell you it's going to take --

Q. I'm not going to ask you to read the whole article. My first question was are you familiar with it at all?

A. I may have heard of it. May not have heard of it.

Q. Okay. Are you familiar with the AAAAI?

A. American Academy of Allergy and Immunology something. I think it's an organization of allergists and immunologists.

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Q. And the journal that this was published in, if you look at Page 2 in the upper left-hand corner, was the Journal of Allergy Clinical Immunology?
A. I would differ with your assertion. I don't know. It's not a journal I subscribe to. Because I'm internal medicine and occupational medicine and public health and general preventative medicine. But that being said, it's not -- This is not -- This article is not famous to me.
Q. Okay.
A. What is famous to me, being an expert in this area, is Bioaerosols: Assessment and Control. That's famous to me. But this article is not famous to me.
Q. Okay. Do you -- Would you -- And I know, understanding you have not read this, but would you have any reason to believe that this article published in the journal of allergy and clinical immunology is not authoritative?
MR. CORWIN: Objection.

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THE WITNESS: I have to read the article to make any comment upon this. So I'll be happy to read it. It starts on Page 326. It goes all the way to -- actually, it's 333. I'll read it if you wish, and then I can comment. But other than -- until I read it, I obviously can't comment upon an article that I haven't read and that I'll say is not famous to me.
MS. FISHER: Okay.
THE WITNESS: It's not -- This is not from occupational medicine doctors. This is not from industrial hygienists. This is from allergists and immunologists. And I have a real question of how an allergist and immunologist would be specifically trained to deal with sorting out causation of disease due to mold exposures. It's not their area. They don't have a master of public health. They don't have training in biostatistics or toxicology or epidemiology. That's why I went into that long discussion about doctors that are specifically trained to sort out causation of disease due to an

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occupational environmental exposure perspective. And -- But with that said, do you want me to read it? I'll read it.
Q. I do not want you to read it at this time. I merely wanted to know if you're familiar with the literature coming out of the -- from the allergists and pulmonologists field.
A. Yeah. I mean allergists and immunologists, in my opinion, is not qualified to render an opinion in this matter because they don't have the requisite training to sort out causation in this type of circumstance, in my opinion. Now -- And I've given you the basis of my opinion, and I've told you that the reason -- that's -- My opinion is corroborated by the fact, to my knowledge, the only three specialties that you have to have a degree beyond a medical degree in order to sit for the boards are the three specialties that are specifically trained to sort out causation of disease and do it as part of their normal practice due to an occupational and environmental exposure,

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and that degree is a Master of Public Health. I know that one can become board certified in allergy and immunology without that additional education. I'll let your allergist and immunologist expert explain why he's qualified and I'm not and why his opinion is correct and mine is incorrect.
But, you know, this paper from -- which I have not read or do not recall reading from this journal is his paper. It's not my paper, and I've provided to you literature cites that I believe corroborate my opinion. And if this is his, I'll let him comment upon that, but it's not mine.
Q. So is it your testimony that there are two or potentially more vastly differing fields of study when it comes to mold and its relationship to health?
A. No. It's my testimony that the proper medical specialty to sort out causation in this matter is one of the three preventative medicine specialties; that being aerospace medicine, occupational medicine, or public health and general

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preventative medicine. And that is why those three specialties are the, to my knowledge, the only three specialties within medicine that require an additional degree in order to sit for the boards. And that additional degree is a Master of Public Health. I'll let somebody else that's not board certified in that area explain why they're qualified. I don't think, if you're not one of those three specialties, that you're really qualified to sort out causation in this matter. And let some -- Let whatever expert you're going to have testify testify to what they think the literature supports or doesn't support. I know what I believe the literature supports. And I have provided corroboration of my opinion at every single point with literature. And I believe that if one is going to look a reliable authority, the reliable authority on this matter is the treatise Bioaerosols: Assessment and Control from the American Conference of Governmental Industrial Hygienists.

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Q. After you created your rebuttal report, have you been asked to do any follow-up work?

A. You mean as far as additional reports?

Q. Yes.

A. No. That's my only additional report.

Q. Other than testifying, do you intend to do any follow-up work?

A. Not as of this point. I may be called upon to review additional records, evidence and testimony. And I will do that if asked to do that by Mr. Corwin. I may be called upon to formulate an additional report or -- an additional report. If I'm asked to do that by Mr. Corwin, I will do that.

MS. FISHER: Off the record.

(Discussion had off the record.)

BY MS. FISHER:

Q. I want to turn back to where we started here, which is your testimony list.

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I see you don't have it in front of you, because I'm the one who has it. And we got -- We were talking about the cases -- you had X'd the cases, put an X in pencil next to the cases that involved mold. And we already discussed one of the cases. Bobbie Vocke case. And I want to ask you a quick question. I'm going to go through a couple more.

Have you ever had a case that was a product-related case -- Have you ever had a mold case that was a product-related case as opposed to a building case?

A. I don't recall one offhand as I'm sitting at this moment. That doesn't mean it isn't the case, but I can't recall one as I'm sitting here at this moment.

Q. Okay.

A. Obviously sort of an unusual circumstance.

Q. I'm looking at a case called He Ma vs. Sigma Management Company in the Superior Court of New Jersey. Is that a case that you remember?

A. Yes, ma'am.

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Q. Evidence deposition in 2014?

A. Yes, ma'am.

Q. Can you briefly tell me what that case was about?

A. That was an individual that rented an apartment, and there was mold contamination of the apartment building. And that individual, in my opinion, suffered disease causally connected to the apartment building, allergic disease. I can't recall specifically what in that individual.

Q. Okay. The next one I'm looking at is Lori Budrow, who is the wife of Kenneth Budrow who is deceased, versus Oak Spur Hills. And that was in the State of Missouri, the Circuit Court of St. Louis County. Do you recall that?

A. Yes, ma'am.

Q. Can you please briefly tell me about that case?

A. Another apartment building, and there were significant water intrusions into his apartment with mold contamination. He's an individual, my recollection, had

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preexisting respiratory disease, I believe, in the form of chronic obstructive pulmonary disease, and then had an episode of respiratory arrest and died. It was my opinion that the respiratory arrest was causally connected to the mold contamination of his apartment.

Q. The next one I'm looking at in reverse chronological order is Lisa Labrake vs. CEI Michigan, LLC and that was in the state of Michigan. You gave a deposition December 13, 2011. Do you recall that case?

A. Yes. I -- obviously further back in time, less accurate recall. But I believe that was a workers' compensation case involving individuals that worked at a telephone company, I think it was AT&T, with mold contamination in the building. And disease that, in my opinion, was related to their mold exposure in that particular circumstance. More recall than that, I don't have at this time.

Q. Okay. And the last one that you've got noted here, at least, is -- And

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I should make clear for the record there is one more that you X'd, but it looks like it's also the same case we talked about with Bobbie Vocke. Looks like you gave two depositions in that case: One in 2011 and one in 2014?

A. One was a discovery deposition and the other was an evidence deposition.

Q. Okay. And the last one is Sam Aiello, if I'm pronouncing that correctly?

A. Yes, ma'am.

Q. A-I-E-L-L-O, vs. Speedwing Investment Company, State of Michigan. Do you recall that case?

A. Yes. It was a case involving, again, apartment occupant and disease due to mold with the apartment occupants. More detail I can't recall because it's some time ago.

Q. Okay. And was your opinion that the occupants had disease related to mold?

A. Yes.

Q. Okay.

A. By the way, just to state, as

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luck would have it, the cases where I actually testified are cases where I was the plaintiff expert. I am currently the expert and have been expert in mold cases where there's mold claims and I have been the defense expert. But based upon my analysis in those cases, the claims were not supported. I'm currently an expert in a mold -- defense expert in a mold case in the area of Rockford, Illinois, where there is a claim on the part of the claimants that a child developed autism due to mold. And based upon my analysis that that is incorrect. So I do expert witness work in the mold -- in mold areas in both behalf of plaintiff and defense if I believe that who is retaining me is correct. If I don't think they're correct, I don't do the work for them.

So that being said, if you're trying to -- somebody is trying to make an assertion based upon this testimony list I'm only a plaintiff expert in mold cases, that's incorrect. Just luck as it has, those are all cases that -- where there is

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actually to the point where there was either deposition or evidence or trial testimony, and luck would have it that those are all plaintiff cases.

Q. Can you direct me to any cases that are not on the list? Because I understand this is -- only goes back four years in which you did give trial testimony or deposition testimony as a defense expert?

A. I can't. Because that's one of the advantages of having a list. I can go back and look at it. So to ask me what my testimony list says would have been more than four years ago, I don't have that type of recall. And, again, it gets into the same issue. Well, I don't know. Does -- the plaintiffs want the deposition. Maybe where I'm the defense expert they don't need the deposition. I don't know why that would be the case, but I do expert witness work, calling it as I see it. And sometimes plaintiff is right. Sometimes defense is right.

Q. With respect to mold cases in

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general, what's your general opinion? Do you think more of them create health effects to the occupants of the buildings, or more of them do not?

MR. CORWIN: Objection. Vague.

THE WITNESS: Yeah. I mean that's -- That question is not specific enough for me to answer. It depends upon the circumstance.

BY MS. FISHER:

Q. Do you --

A. Sometimes I'm a plaintiff expert, sometimes a defense expert. It all depends upon the specific circumstances of a particular case. I do believe that you can get sick due mold exposure, okay? But it all has to do with what are the exposure circumstances, what are the claimed illnesses. It'll be -- It's very much dependent upon the particular case.

Q. I'm going to hand you another exhibit.

(Document marked as Dr. Chiodo Exhibit No. 6 for identification.)

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BY MS. FISHER:

Q. State for the record it's a New York Times article from 2008. Are you familiar with this article?

A. Yes, ma'am. I was quoted in it.

Q. If you need a second to refamiliarize yourself.

A. Well, just point to me where my quote is.

Q. It's on the very last page.

A. Okay.

Q. And there is a quote. And first you should let me know if that is an actual quote. I think you already testified that it is, but let me know if you were somehow misquoted.

A. Personal injury lawyers are already -- This is a -- This, by the way, put it in context for somebody reading the transcript, this is a quote from the New York Times. They called me up. I guess that indicates that I'm a pretty well-qualified doctor. New York Times usually calls up guys that they think are

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pretty well qualified. So I thank them for the compliment.

And it was an issue about whether or not there's adverse health effects that people have to worry about about radiation emitted from granite. Because granite can emit radiation. Some granite and some granite countertops can be from areas where there's very high concentrations of radioactive materials. So there can be substantial emission of radiation from granite countertops. And I was asked to comment upon the following: That personal injury lawyers are already advertising on the web for clients who think they may have been injured by countertops. And I said, and I don't think they misquoted me, I think there would be a lot of -- it would be a lot like mold litigation a few years back, where some cases were legitimate and a whole lot are not. And I'm no different. Some mold cases are legitimate. A whole lot are not. Some -- You can sit down and say, well, it depends what you're looking at. Maybe a

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lot are legitimate and a whole -- and opposing mold cases, a whole lot of opposition are not legitimate. But, you know, some are -- some are legitimate, some are not.

Q. And that's your view?

A. That's my view. Tell me the -- Give me the specific case, have me take the time to formulate the opinion on that particular case, and I'll tell you if I think it's legitimate. I'll tell you if I think it's not legitimate. That's why I can be -- you know, some cases I'm the expert for the plaintiffs. Some cases I'm the expert for the defense.

Q. Did you ask in this particular case for any particular materials when you were contacted?

A. You're asking me to recall my conversation from a number of months ago. I don't recall my conversation with any specificity. In general I say send me everything you have. And I think, to my knowledge, that's been done.

Q. Okay. So the types of things

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you would want to review are medical records?
A. Yeah. Medical records that were sent to me.
Q. Okay. You'd want to -- at least interview the patient and do a patient history?
A. Not necessarily. Sometimes I can do things based upon record reviews.
Q. Okay.
A. Because it gets into the whole analysis of, you know, when you deal with any exposure case, any toxic tort case, because mold is basically toxic tort cases. They're in that category. Exposure, general causation, specific causation. So sometimes I can sort out these different issues based just upon the records. Sometimes I have to see the individuals. It all depends upon the individual circumstance.
Q. Do you need to see the individual's home?
A. No. Not necessary -- Usually I don't have to go -- Sometimes I'll be

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called upon and asked to do an inspection. And if it's not too far away, I'll do that for the stated fee. If not, if I have to travel some distance, it'll be an additional fee. But, no, I can -- I can do that -- do an analysis based many times upon just the industrial hygiene records that I'm provided, such as in this case. I believe I have sufficient information to render an opinion about whether or not -- about the issues in this matter without me personally inspecting the mattress and personally obtaining the samples. And usually I'm not the one called upon to do that.
Q. The person called upon to do that, do you believe that should be an industrial hygienist?
A. It depends. I think in this context you need -- what you need is -- to comment upon it you need an industrial hygienist. The person obtaining the samples is usually not an industrial hygienist. Many times it's a technician. And then you need an industrial hygienist

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to be able to critique and say, yeah, I think this is satisfactory. And in this case I believe what was done by Ms. Duncan was satisfactory. So -- But usually the person doing this -- obtaining the samples is not an industrial hygienist. Sometimes it may be. The analogy is in the hospital. Say I need blood work done on Patient Jones. Who obtains the blood sample is not the physician. It's a phlebotomist. Phlebotomist is a technician. The blood sample is obtained by somebody other than the learned professional who's the physician. So very analogous in this matter.
Now, I believe that I have sufficient understanding of the circumstances here in the process engaged in by Ms. Duncan; that is, taking samples from the visible mold, tape samples, I believe they were, and then sending those utilizing proper chain of custody, which I understand she did, to a testing laboratory for the testing laboratory to analyze the samples and report back that the samples

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are indication of cladosporium and that there was heavy infestation of the sample. I believe that that is perfectly fine and satisfactory. I have absolutely no questions, concerns, qualms about the mold testing in this matter.
Q. You say --
A. And I'm saying that not just as a doctor. Because just a doctor wouldn't be qualified. I'm saying that as a doctor that's also a certified industrial hygienist and enough of a reputation in the profession to be the president -- former president of the first industrial hygiene organization in this country, which was the Michigan Industrial Hygiene Society. Why Michigan Industrial Hygiene Society? Occupational medicine industrial hygiene really got their start in the Detroit area because of the auto plants.
Q. At different times in your answer both used -- used both the singular and the plural for sample and samples. Are you -- Do you know how many samples Ms. Duncan took?

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A. I don't know. I don't think it's -- If she went and took one tape sample, that would be satisfactory. If she took multiple, fine. But if she took one tape sample and it was representative of what she saw as the mold contamination, I believe that's satisfactory. And I would call upon somebody else that's rendering an opinion contrary to be able to support their opinion with what would be a recognized treatise.

Q. Do you believe it would have been important for somebody to take an air sample of Mr. Simon's bedroom while he was in it, sleeping in it, at the time that he alleges he was sleeping on a Sleep Number bed and it was contaminated from mold?

A. No. First off -- no. It's not relevant. Air sample. Why would you get an air sample in some other portion of the room? He's sleeping on a moldy mattress. Okay? You know, the question of the mold levels some place away from his -- Let the record reflect that me putting my head down on this table like somebody laying on a bed

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with his mouth right down by the surface of the mattress, his body, dermal exposure to the -- to the moldy mattress. Doing air samples just is not, in my opinion, relevant.

Second problem with your assertion is, wait a minute, how are we going to go back in time? When he found out that the -- By the time that he found out that the mattress was moldy, my understanding he stopped sleeping on it. So how are we going to go back in time and do air samples if they were, in fact -- had any relevance prior to the time of his discovery, because he didn't even know that there was a moldy mattress. That's part of the problem. He didn't know, and, therefore, his doctors didn't know, and that led him to have complication of disease due to the inability of his doctors to diagnose the cause or understand the cause, because they didn't know about the moldy mattress.

Q. Would it be important to you if somebody did mold samples on the surface of

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the bed? You mentioned contact surface, contact dermatitis.

A. Do you have such samples? Somebody did that with this particular mattress, with this identity of circumstances versus the circumstance where your industrial hygienist did a testing that, in my opinion, was -- appears to be designed to minimize the mold exposure.

Q. Well, the question is, is would it matter to you if somebody had taken mold samples on the surface of Mr. Simon's bed and other portions of the bed?

MR. CORWIN: Objection. Vague as to time.

THE WITNESS: Yeah. I mean, the bottom line is -- bottom line is that I believe the samples that were obtained were proper. I don't think that you have to say that in order for them to be proper to document the mold contamination that you have to do mold contam -- sampling at the -- on the surface on his sheets. I don't think that would necessarily be representative of what his exposure would

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be in over time, sleeping for now apparently years on a moldy mattress. And his manifestation of disease due to the allergic exposure, and along with what your expert allergist immunologist, Dr. Wedner, believes that this is a highly-allergic individual. If somebody is allergic to mold, you can get manifestations of allergic disease with minute exposures. And his claim that somehow there's some type of threshold, you need 3,000 -- It's 3,000 spores per meter cubed to have some manifestation of disease, I just disagree with that type of assertion.

BY MS. FISHER:

Q. If an individual is highly allergic to cladosporium mold, wouldn't they have manifestation when they walk outside on a high mold spore count day?

A. Again, he's the one that's saying he's highly allergic. I'm saying that he's fine now because he's not sleeping on a moldy mattress contaminated -- contaminated with cladosporium. He was fine as far as his

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allergic manifestations before he was sleeping on a moldy mattress. But when he was sleeping on the moldy mattress, that's when he developed manifestation of disease. So that's my understanding of facts and that allows -- that is part of the analysis that allows me to opine in the, I believe, the properly-trained specialty, occupational and environmental medicine, to determine causation of disease as it relates to the mold exposure in this matter.

Q. If he was symptomatic to his sensation -- sensitization. And correct me if I'm wrong. I understand you can allergic to something on a skin test. That doesn't necessarily mean you'll be symptomatic when exposed to that allergen; is that correct?

A. Again, such a vague question. Let me state it this way. We know he was symptomatic. He had problems when he was sleeping on the moldy mattress. The mattress was contaminated with cladosporium. We know that based upon the

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testing. When he -- Before he started -- Before the time period where the mattress was moldy and he was sleeping on it, he didn't have the allergic problems that he had. Then when he stops -- When he discovered the moldy mattress and he stops sleeping on it, his symptoms either completely resolved from allergic disease or largely resolved. I believe that that -- that is consistent with my analysis of causation. That's the only way I can answer the question. Because otherwise the question is just so vague, you know. Again, we're not talking in vagaries. We're talking about this particular case and my analysis in this case.

Q. Well, let me give you a hypothetical that applies to Mr. Simon. He's allergic to, according to his skin test, multiple types of grass and tree pollens.

A. Mm-hmm.

Q. Is it possible that he is sensitized to grass and tree pollens, but he may not be symptomatic when he

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encounters those grasses and tree pollens?

A. I don't differ with the assertion that he has some type of allergic sensitization, but he didn't have allergic manifestation; that is, I think you're making my point. He can be allergic to a lot of things. He was fine when he wasn't sleeping on the mattress contaminated with mold. When he he's sleeping on the mattress contaminated with mold, unbeknownst to him, because it was a latent, hidden defect, then he had problems. So that's the point. And if, in fact, he had problems -- if somebody is trying to make an assertion, well, he's allergic to pollen and he's allergic to this and that, trees, and -- well, then why isn't -- Why doesn't he still have the same problems now because the same type of pollens are -- the same type of pollens are there that he was exposed to before he bought the Select Comfort mattress, the same type of pollens are there while he had the Select Comfort mattress, and the same type of pollens and tree allergens are

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there after he discovered the mold on the Select Comfort mattress and stopped sleeping on it. So how does pollen, tree allergens, how does that figure into that? Now I'll leave that to your expert to explain that, but the picture doesn't fit. And it's a matter of having the picture fitting that is part of the deductive logic process of a differential diagnosis of etiology. Again, and that whole issue is described in the Reference Manual of Scientific Evidence, Third Edition.

Q. Let me try to ask you the question a little bit more clearly.

Mr. Simon is, I'm just going to pick one that he is sensitized to, according to the skin test that you just -- that you reviewed a little while ago. I'm going to pick spiny pigweed, because I like how it sounds. Is it your understanding of the allergy response and the way that the human body may or may not respond to something that it's sensitized to, that you can have a reaction to spiny pigweed on your skin, on your skin test that you

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reviewed, but somebody can wave it all under your nose and you actually won't be symptomatic of that. You won't -- you won't have any outward symptoms of that allergy. Is that your understanding of the --

A. It all depends upon the amount of allergic sensitization, what the exposure is. A lot of people aren't allergic to tobacco, okay. And they can be allergic to it and be in a room by somebody smoking a cigarette and have allergic symptoms or not. Maybe some people can smoke and be allergic and have allergic symptoms or not. It depends on the extent of their sensitization and a reaction to the sensitization. So, you know, it's -- it gets down to what are the facts.

Q. So, in your opinion, Mr. Simon is not only allergic on his skin test to cladosporium, but also has -- when exposed to cladosporium he has -- he's symptomatic. He has allergic reactions to it?

A. No. This is my opinion. My opinion that he had symptomatology when he

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was sleeping on a mattress, moldy mattress, that included clado -- that included, appears to be, cladosporium contamination. And then he had an allergic manifestation due to that. Now, there is cladosporium in the environment. There's cladosporium in this air. It's, I believe, the most common mold, outdoor mold, in North America. That's my recollection. So he may be allergic to cladosporium. There may be plenty of cladosporium in the air in St. Louis. There was plenty of cladosporium in the air in St. Louis now after he's no longer sleeping on the moldy mattress. There was plenty of cladosporium in the air in St. Louis before he was sleeping on the moldy mattress. But its manifestation of disease, allergic disease, happened when he was sleeping on the moldy mattress. So somebody is trying to sit down and say, well, you know -- I'll let somebody -- I'll let your expert explain why that factors into their analysis. I've just told you why I think that -- you know, you can be allergic to cladosporium. He's

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not having the problems that -- now that he had when he was sleeping on the moldy mattress. He didn't have the problems that he had when he was sleeping on the moldy mattress before he was sleeping on the moldy mattress. What were the factors? Sleeping on a moldy mattress with cladosporium. That's the difference in exposure versus cladosporium in the air. He had cladosporium in the air at the time, if it's properly seasonal, when he was sleeping on the moldy mattress. He has exposure in the proper season to cladosporium in the air when he's not sleeping on the moldy mattress. But the factor that led to the -- the circumstance that led to his manifestation of disease was sleeping on the moldy mattress.

Q. So it's your opinion that it's a matter of exposure level?

A. No, no. It's my opinion it's -- In his case, it was sleeping on a moldy mattress. It isn't a matter of exposure level or not. It's that he was sleeping on a moldy mattress and he's -- he

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is -- had allergic manifestation of disease due to sleeping on the moldy mattress. Now, he may have allergies to cladosporium, but he's not sleeping on a moldy mattress anymore, so he's not having problems. It's as simple as that.

Q. Well, I don't find that simple because you say it's not due to exposure level.

A. No, no, no, no, no.

Q. But you say that the -- explain to me why the cladosporium in the air will not affect him, but the --

A. I understand. Okay. I understand. I think I understand.

There are no exposure limits for biologics. If you go to OSHA, there is a permissible exposure limit to chemicals. Like carbon monoxide, the permissible exposure limit to carbon monoxide is 35 parts per million. Because we know that, you know, some people are going to have problems below that. But from a societal standpoint we have decided that, you know, some people are going to have problems

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below 35 parts per million to carbon monoxide, but we still have to have some exposure to carbon monoxide in our society.

There are no such analogous exposure limits for biologics such as mold. Because if you're allergic to mold, even one mold spore could cause you to have adverse allergic reaction. Even one mold spore could cause a susceptible individual to have an anaphylactic reaction. Even one exposure to other biologics could cause such a reaction. That is why there are no exposure limits within -- for biologics within industrial hygiene. There are exposure limits to other chemicals -- to chemicals and other substances, but not to biologics.

So your question can't be answered that way because it assumes that there are levels. That's not how the analysis is done as far as biologics, including mold. So there's a false premise in your question. And I'm not saying that to insult you. It's just that there's a false premise in your question.

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Q. Well, I think you may have misunderstood the question. Because I wasn't asking for a number or a cutoff. I'm asking for a relative comparison.

So is it your opinion that a relative -- with respect to relative comparison he was exposed to a higher level of mold by sleeping on the mattress than he's exposed to when he goes outside during the mold season?

A. Level is the wrong word to use. He had a different exposure circumstance. There are no -- You don't use levels when you're talking about biologics. That's part of the problem with your expert's opinion. His opinion is not consistent with what would be generally accepted. It is junk science, Dr. Wedner. He may be a well-educated man, but it's junk science. There are no levels for biologics. That's part of the reason why what he's saying is junk science. And let him defy that opinion I've just said by showing me what the exposure limits are for biologics from an occupational environmental exposure

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standpoint, because there are none because even a minute quantity of allergic substance can cause somebody to have serious disease or death. That's why when you get on an airplane and some kid has peanut allergies on the plane, they just -- the airline doesn't let the peanuts be distributed. Because even a minute amount could cause somebody that's -- that has a severe allergy to peanuts to go into anaphylactic shock and die. And I have, contrary to what Dr. Wedner is saying, I've seen that happen, okay? So even a small amount of a substance to which somebody is highly allergic to can cause serious disease and death.

In this case, we're not talking about Mr. Simon having anaphylactic shock. We're talking about him having allergic disease manifested from sleeping on a moldy mattress for years because he didn't know about it. But the serious disease like anaphylaxis that can happen with even a minute quantity is why there are no biologic exposure limits to mold, other

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biologic substances, you know, organic substances like that. And so when you start using the term levels, it's just the wrong use of the term. That's why your wrong -- you got the wrong type of expert in an allergist immunologist. If you'd hired an occupational medicine doctor, I think they'd probably have to agree with me. And even if they didn't, they'd have the right specialty. Dr. Wedner is the wrong specialty. Because if he was the right specialty, he would have never said anything as absurd as he said. It's just the wrong type of doctor. Not saying he isn't a fine allergist and immunologist, but he's not -- You picked the wrong expert. If anybody is talking about levels, it's the wrong use of word in this matter.

Q. Put aside the word level. I'm still somewhat confused by an opinion that would state that Mr. Simon was symptomatic while he was laying on the mattress but can -- would not be symptomatic when exposed to cladosporium

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when he goes into the outside air?
A. Why are you puzzled by that? He was symptomatic when he was sleeping on the mattress. The mattress was contaminated with mold. Now he's not sleeping on the mattress. There's still cladosporium in the air. He's not symptomatic. That's the fact. That's how it is. Why is that? Sleeping on a moldy mattress is a different circumstance than having just cladosporium in the normal air. I don't see what is so difficult with that concept. And I think a jury is going to sit down and they're -- you know, the lay jury is going to have the same thought that I have in that context. Now, you need an expert to testify to these issues, but I don't -- I'm surprised that you're surprised. I really am.
Q. Can you explain to me how it's a different circumstance?
A. You're sleeping on a moldy mattress. The mattress is moldy. That is different than not sleeping on a moldy mattress.

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Q. Are you familiar with where the mold was allegedly located in the mattress?
A. Yes, I am.
Q. You're familiar it was located inside the mattress and not on the outside of the mattress?
A. Ma'am, I'm prepared to testify as a biomedical engineer about the design defects in this. I have enough understanding of the circumstance. And I believe in this context he would have had exposure. That you would have had from compression of the mattress, being on the mattress, the moldy mattress, the material, that there's no -- there is no material like an impermeable barrier between the mold inside the mattress and his exposure. Part of the reason why you have mold is that there's an impermeable barrier to keep vapor from penetrating through. A normal bed, it would just penetrate through. It would just continue to go through, and you wouldn't have liquid water formation at the point as you have with an impermeable barrier. So -- But he's going to have

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exposure due to this. And I think any assertion by an individual saying otherwise, I leave them to sit down there and support their opinion and support their opinion with literature that would say contrary. I believe that this clearly would have led to his exposure. You push down on that mattress, you push down on the mattress, push down on any mattress, you feel like a little whoosh of air come back up.
Q. So --
A. That's what would have happened with this mattress, and that little woof of air would have had -- would have had fungal particles coming back up, and you would have had exposure. And there is no impermeable barrier between him, his exposure to his skin, the respiratory exposure, nasal and other airway to the mold because this is different than your initial analogy where you said you took a moldy material and you put it into a bag, impermeable bag, and had it wrapped up; and, you know, is somebody going to get

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exposed. That's not the case here. The case here is that there is no impermeable barrier.
Q. So it's your opinion then or you theorize that the mold spores and particles from inside the bed became aerosolized and came outside the bed?
A. No, no. It didn't have to get outside the bed. All we had to do is have skin contact to the substance that he's allergic to. Even in minute quantities you can have allergic manifestation. Now, I don't say that it was minute quantities. He's sleeping on a moldy mattress, and he had allergic manifestations as a result. So I know that there's some theory that's -- your expert is trying to formulate that says that, no, he would not have had mold exposure to any mold particles because it's deep in the mattress. And somehow Dr. Wedner is saying that the mold spores have to germinate in order for people to have any type of allergic disease. I think that's all -- that is junk science. And I'll leave your

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experts to support their opinion with peer-reviewed literature, just like I've been able to do at every point of this process when called upon do so.

Q. I'm still -- I just want to make sure I'm clear on what your testimony is with respect to -- you've testified that there has to be exposure in general?

A. Yes. You have to have exposure in order to have the disease due to exposure, yes.

Q. And it's your testimony that lying on the bed gave him exposure?

A. Yeah. A mattress contaminated with mold gave him exposure.

Q. And exposure was both through contact through his skin, was one type of exposure; and the other type of exposure was breathing in the spores?

A. And/or both.

Q. And/or both. So those are the two methods of exposure that you're basing your opinion on?

A. The only one I can think of is that. I don't see any ingestion. And I

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don't think he was injecting mold into him intravenously. So it's dermal and/or respiratory.

Q. If he was symptomatic when coming in contact with mold spores, either through dermal means or respiratory means, he would be symptomatic if he came into contact with cladosporium again in one of those two or in combination?

A. No. Not necessarily. Sleeping on a moldy mattress is different than a circumstance where you're not sleeping on a moldy mattress. So I think what you keep on trying to come back to is he would have some allergic manifestation of the same time when he comes into contact with cladosporium and there's cladosporium in the air; and, therefore, this is all nonsense. That's what your experts are saying. And I'm saying, no, that's wrong. Sleeping on a moldy mattress is different than the same circumstance with him where he's not sleeping on the moldy mattress. And when he was sleeping on the moldy mattress he had the allergic manifestation

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of disease that led to the issues in this case. And before he was sleeping on that moldy mattress, he didn't have that allergic manifestation of disease. And after he was done sleeping on the moldy mattress, he did not have the same allergic manifestation of disease. So that ties in with the differential diagnosis of etiology, the recognized scientific methodology for a physician to use in this matter, and specifically an occupational medicine physician to sort out and formulate a differential diagnosis of etiology as to the cause of the disease, and that leads me to the mattress.

Now, I'll let your experts explain what you're trying to say is, well, gee whiz, Doc, I can't understand. He's allergic. Why isn't he allergic when he's out in the air and he's not sleeping on the moldy mattress? Well, he's not. And that's not -- That's not what's happening to him. So he doesn't have the same manifestation of allergic disease if he's not sleeping on the moldy mattress. So,

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you know -- And that's how it is. Sometimes, you know -- So he's not having the same exposure circumstance not sleeping on the moldy mattress as when he was sleeping on the moldy mattress.

Q. Do you have any cases in this list in Exhibit 1 or others in your history that you can tell me about in which you've opined about some sort of disease or toxic substance related to mattresses before?

A. No. I don't -- I don't recall any. If I -- if there is, I don't recall any offhand. I doubt -- Obviously I deal with issues, and I deal clinically with issues with mattresses, because I used to be, in addition to caring for individuals with catastrophic injuries, quadriplegics and severe head injuries in the home care setting, I was, for over ten years, the medical director of the visiting nurses of Southeast Michigan, which was the largest and oldest not-for-profit nursing organization in the state of Michigan. It was founded in 1898. So I have more than the average physician's understanding of

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beds. Because you have to have that if you're dealing with home-bound people and people that are susceptible to disease that can be caused by beds like decubitus ulcers. And I am, of course, a biomedical engineer. But I don't recall offhand any testimony on that testimony list that has specifically to do with mattresses. But then again, that doesn't mean that I don't have my knowledge, training, and experience that would be relevant in this matter if called upon to testify about specifically the mattress and the biomedical aspects -- biomedical engineering aspects of the mattress. The fact that I haven't testified on that issue before doesn't mean I don't have expertise.

Q. Let's go back to -- We had talked about what you do, your different practices. Do you try cases right now?

A. Yeah. I have tried toxic tort cases, and I have been an attorney in various toxic tort cases. And I have tried administrative law cases also.

Q. Have you tried any in the last

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five years?

A. Yes. The last five years. I tried one in California in 2009. It was a toxic court case in Sacramento, California. Since that time I have not had a case that went to trial. And it's not a major portion of my practice. I do it from time to time.

Q. Okay. And I think that we established that the majority of your income is derived from expert services?

A. Well, again, I don't -- That's my impression. I won't differ with the assertion that 90 percent or more comes from being a forensic expert. But I don't really know with absolute certainty that that's the case, because I don't -- I'm a numbers guy. I don't just guess at percentages. That implies -- percentage implies some type of precision.

(Document marked as Dr. Chiodo Exhibit No. 7 for identification.)

BY MS. FISHER:

Q. Do you recall this article that

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it looks like you were interviewed for earlier this year?

A. Yes. It looks like I'm a distinguished alumnus of Wayne State University Law School.

Q. Have you seen this before?

A. Yes. Most definitely. I'm very proud of this. Contact -- Wayne State contacted me because they wanted to write an article about me. Wayne State University Law School.

Q. So on the second page, and I understand that this is a printout from a -- from the internet, so the pages might be a little funny. Just over halfway down right after seven questions, this article states that you actively practiced both medicine and law. And it says, quote, but his primary source of income is his work as a forensic medical expert witness for trials. Is that true?

A. Isn't that consistent with my testimony?

Q. I'm not suggesting it isn't. I'm just asking is that true?

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A. Yeah. I believe so. That's my impression.

Q. And then the --

A. Now, they didn't ask me under oath to sit down and throw out a percentage. But I think -- I think my main focus is as a forensic medical expert; just like a forensic pathologist, 100 percent of their time is as a forensic expert. Because you don't want to have a country doctor figuring out if somebody was murdered or not.

So I have expertise most physicians don't have, and it comes into play with forensic issues. So that's most of what I do. I'm very proud of it. I'm not an amateur doing this. I'm -- This is what I do. It's like the guys on CSI. They're doing -- They're not taking care of sore throats and then going and doing their forensic analysis. I do take care of a few sore throats still, because I still have a clinical practice. But most of what I do is forensic medicine. Because that's -- because I have that type of background.

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Q. And the quote just below that paragraph. "That's my main activity and it's very lucrative"?
A. That's a fact.
Q. That's your quote?
A. That's my quote. It is my -- That's my main activity and I would have -- I think anybody would agree $1,000 an hour testifying is lucrative. And I would agree with that.
Q. How many cases do you take on in a year roughly?
A. I don't keep a log. I don't know. It's something I do. I do a lot of forensic work, but I can't quantify it.
Q. Is it so many that you need to have an agency manage your work?
A. No. I don't think an agency manages my work. There are different companies and agencies that will look for expert witnesses in different issues, and there'll be a middleman between me and the ultimate person desiring the expert witness work. But I'm -- I manage everything myself.

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Q. Do you market your services?
A. Who doesn't? Who doesn't? Hospitals market their services. Doctors market their services. I mean who doesn't? I mean we're, you know, that's -- Who doesn't? So yes, of course I market my services. I don't market a lot. I mean I don't spend a lot of time in marketing. I have the type of background the work comes to me. But I do have listed on expert witness directories people are able to find me via the internet. And, of course, word of mouth.
Q. Do you know how the plaintiff's attorney in this case found you?
A. No.
Q. Have you ever worked with him before?
A. No.
Q. Have you ever worked for the firm Sher Corwin Winters before?
A. No.
(Document marked as Dr. Chiodo Exhibit No. 8 for identification.)

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THE WITNESS: Actually, I think we're going over time.
MR. CORWIN: We're fine. I'll monitor it.
THE WITNESS: That's fine.
MR. CORWIN: I appreciate you thinking about me.
THE WITNESS: Yes, ma'am. I'm at your service. You go right ahead.
BY MS. FISHER:
Q. Do you know who Prime Time Legal Services Agency is?
A. Yes. This is -- This is an interesting guy. This is a classmate of mine from business school, at the University of Chicago Business School. And I ran into him. Because I'm the -- I'm one of the -- I'm the co-chairman of the University of Chicago Booth Health Care and Biopharma Round Table. And -- I happen to run into him at the University of Chicago's Gleacher Center campus, and he asked me what I did, and I told him. He had known of me before from business school. And he said, well, God, I'd like to market your

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services. I said, feel free to do so. Now more than that, I don't know. He put out whatever he put out. This is not something that I put together. I haven't received any work from him. I don't know if he defamed me in this at all. Let me know if you think he defames me. But, you know, somebody -- somebody marketing my services. And I don't have a problem with somebody doing that. That's perfectly fine and they put a markup on it. That's called American business.
Q. In your South Florida business do you have a web page in which people who believe they've been injured by mold can write in, fill out a questionnaire, and send it in to you?
A. If it's termed that people injured, I would say people that have issues concerning mold or toxins. It's not solely plaintiffs. In fact, I do a lot of work and analysis on behalf of defense in Florida. And they find me through that website. So your -- I disagree with your assertion that it's somehow geared towards

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plaintiffs. It's geared towards anybody that has this concern. It's pretty hard to find somebody with the right expertise concerning toxicology and mold anywhere, and including South Florida. So I --

(Document marked as Dr. Chiodo Exhibit No. 9 for identification.)

BY MS. FISHER:

Q. Is this a printout of the page of your website in South Florida, Mold and Toxicology Center?

A. Yes, ma'am. It looks like it. Exhibit 9. Yes, ma'am.

Q. On the left-hand side our focus, the first bullet is, or I guess it's not a bullet, the first statement is mold and building illness.

A. Yes.

Q. If you click on this link learn more, is that where the, to your knowledge, is that where the form pops up that people can write to you and ask for your consulting services?

A. I don't know. I didn't put

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together the website. And I'm not a techie. I'm not a web type of person, so --

Q. But you understand --

A. I won't differ with your assertion. I don't -- By the way, if somebody tries to communicate with me through via e-mail, that's not how I do it. If they want to contact me -- and I guess that's the modern way. Usually I prefer somebody calls me. If somebody sends me something about mold, I'll say -- you know, call them up and say, I'd be happy to talk to you. But I don't -- I don't communicate back and forth with e-mail. If that's contact access point, I'm not differing with the assertion. I don't know. I didn't put together the website, and I don't spent a lot of time horsing around with it. I do market, but I don't have to put a lot of time into marketing. I do not have to put a lot of time into market.

Q. And I apologize. I lied when I said I promise, because I actually do have a copy of this, and I just want you to

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identify it.

(Document marked as Dr. Chiodo Exhibit No. 10 for identification.)

BY MS. FISHER:

Q. Is this also a printout of the website from South Florida Mold and Toxicology Center?

A. It looks like it.

Q. Okay. Let's go off the record for one minute.

(Discussion had off the record.)

(Short break taken.)

BY MS. FISHER:

Q. I have one question. Are you familiar with what a confounder is?

A. Confounder is an epidemiologic term that has to do with one circumstance going along with another circumstance that is the actual cause. The classic example of a confounder is if you look at the rates of homicide in a city and the rates of ice cream consumption, the rates of homicide will go up as the rates of ice cream

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consumption go up. Well, in that case, ice cream is not causing people to commit homicides. It isn't the sugar rush. It's because ice cream consumption goes up in sales when the weather is hot. And when the weather is hot, people are outside, they're -- it's hot, they're agitated, they're more likely to commit homicides. That's an example of a confounder.

Q. I have nothing further today.

MR. CORWIN: Read and sign or waive?

THE WITNESS: I don't care. It's up to you. I prefer to waive.

MR. CORWIN: Okay. We'll waive.

(Witness excused.)

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, LAURA MUKAHIRN, Certified Shorthand Reporter and Notary Public in and for the County of Cook, State of Illinois, do hereby certify that on August 20, 2015, the deposition of the witness, DR. ERNEST CHIODO, called by the Defendant, was taken before me, reported stenographically, and was thereafter reduced to typewriting under my direction.

The said deposition was taken at the offices of 227 West Monroe Street, Chicago, Illinois, and there were present counsel as previously set forth.

The said witness, DR. ERNEST CHIODO, was first duly sworn to tell the truth, the whole truth, and nothing but the truth, and was then examined upon oral interrogatories.

I further certify that the foregoing is a true, accurate, and complete record of the questions asked of and answers made by the said witness, DR.

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ERNEST CHIODO, at the time and place hereinabove referred to.

The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

Witness my official signature and seal as Notary Public, in and for the County of Cook, State of Illinois, on this 25th day of August A.D., 2015.

Laura Mukahirn

LAURA MUKAHIRN, CSR
CSR NO. 084-003592

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